Exploring Women's Perspectives on their Past Experience of Postpartum Depression and the Infant-Mother Relationship: An Interpretative Phenomenological Analysis

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Abstract

Postpartum depression (PPD), is the most common complication of childbirth, with wide variability in onset, symptomology, severity and chronicity. Despite extensive research attention, the condition is often undetected and untreated. PPD has an impact on the mother-infant attachment relationship. However, the mechanisms of negative influence of PPD on infant attachment remain unclear. The majority of qualitative studies of PPD have been completed with women who are currently experiencing an episode of PPD. In addition, few qualitative studies have focused on women's experience of caring for their baby during PPD. The aim of the current study was to qualitatively explore the experience of PPD and the mother-infant relationship, with women who have recovered from PPD.

Eight women participated in semi-structured interviews, reflecting on their personal experiences of postpartum depression and how it impacted on their relationship with their infant. The Interpretative Phenomenological Analysis (IPA) of the data from these eight interviews revealed three superordinate themes; 'Feeling Inadequate', 'Fear-Filled Caregiver' and 'Journey to Recovery'. These themes are discussed in the context of the previous literature. Implication for clinical practice and future research are explored.

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CHAPTER 1: INTRODUCTION

1.1 General Overview

The aim of the current study was to qualitatively explore the experience of postpartum depression (PPD) and the mother-infant relationship, with women who have recovered from PPD. A review of the literature indicated that there is an abundance of quantitative research into postpartum depression. However, PPD remains the most common complication of childbirth, with poor rates of diagnosis and treatment, and negative outcomes for the mother-infant relationship (Dennis & Chung-Lee, 2006; Field, 2010).

Although there have also been substantial qualitative studies completed on postpartum depression, the majority of studies have been completed with women who are currently experiencing an episode of PPD. In addition, there is a dearth of studies with women reflecting on their experience of caring for their baby during their PPD. The current study sought to address this gap in the literature.

1.2 Structure of Thesis

1.2.1 Chapter 2: Literature Review

A review of the existing literature on postpartum depression is provided in this chapter, including the symptomology, diagnosis, prevalence, risk factors and treatment options. Qualitative studies of postpartum depression are reviewed, with a specific focus on the qualitative literature relating to the mother-infant relationship. Attachment theory and the key concepts and mechanisms are explored, in order to provide context, to how postpartum depression may impact on the mother-infant attachment relationship. The chapter concludes by

providing a rationale for exploring women's experience of postpartum depression and the mother-infant relationship. The research questions are then outlined.

1.2.2 Chapter 3: Methodology

This chapter firstly provides a rationale for the qualitative methodology chosen, followed by a description of Interpretative Phenomenological Analysis (IPA). Information on the participants, procedure and ethical considerations is also provided. A detailed description of the data analysis is outlined, reliability and validity considerations are discussed and reflections on the research process are considered.

1.2.3 Chapter 4: Results

This chapter will present the results of the Interpretative Phenomenological Analysis (IPA) of interviews with eight women about their past experienced of postpartum depression and caring for their baby during this time. The analysis revealed a number of subordinate themes with three overarching, superordinate themes. A description of each theme is provided, illustrated by excerpts from the interviews.

1.2.4 Chapter 5: Discussion

The final chapter provides a review of the aims of the current research, followed by a detailed discussion of the findings, with reference to the relevant literature. Limitations and strengths of the study are considered and the implications of the findings in terms of clinical practice and future research are discussed. Finally, the researcher's reflections and comments on the project are provided.

CHAPTER 2: LITERATUTRE REVIEW

2.1 Chapter Introduction

This chapter reviews the existing literature on postpartum depression, including the symptomology, diagnosis, prevalence, risk factors and treatment options. Qualitative studies of postpartum depression are reviewed, with a specific focus on the qualitative literature relating to the mother-infant relationship. Attachment theory and the key concepts and mechanisms are explored, in order to provide context, to how postpartum depression may impact on the mother-infant attachment relationship. The chapter concludes by providing a rationale for exploring women's experience of postpartum depression and the mother-infant relationship. Finally, the research questions are explicated.

2.2 Postpartum Depression

2.2.1 Definition

Postpartum Depression (PPD) is most commonly defined as a depressive episode which occurs within the first year following childbirth (O'Hara & McCabe, 2013). Onset is typically within two to twelve weeks of delivery (Pawar, Wetzker, & Gjerdingen, 2011). Research suggests that the symptomology of PPD is similar to depression which occurs in the non-postpartum period (Buttner, O'Hara, & Watson, 2012). The main symptoms include depressed mood, tearfulness, despondency, emotional lability, loss of appetite, sleep disturbance, poor concentration and memory, fatigue and irritability (Robertson, Celasun, & Stewart, 2003). However, depression in the postpartum period has some distinctive features (Brummelte & Galea, 2016). Qualitative

literature has highlighted a number of prominent features of PPD including anxiety, obsessive thoughts, guilt, feelings of inadequacy and feeling overwhelmed (Beck, 2002; Hendrick, Altshuler, Strouse, & Grosser, 2000; Robertson et al., 2003). In addition, women with onset of PPD which occurred within two weeks of delivery were more likely to develop bipolar disorder than women with major depression in the non-postpartum period (Munk-Olsen, Laursen, Meltzer-Brody, Mortensen, & Jones, 2012).

2.2.2 Postpartum Blues

Postpartum Depression is distinguished from the more common postpartum blues, a mild, transient, mood disturbance experienced by 40% to 80% of women three to five days after delivery, lasting several hours to days (Buttner et al., 2012). Postpartum blues are characterised by emotional lability, low mood, anxiety, irritability, tearfulness, sleep and appetite disturbance (Robertson et al., 2003). The risk of postpartum blues does not increase with psychiatric history, environmental stressors, cultural context, breastfeeding, or parity, however, these factors may increase the risk of postpartum blues progressing to postpartum depression (Miller, 2002).

2.2.3 Postpartum Psychosis

PPD is also distinguished from postpartum psychosis, a rare, acute, psychotic episode, which occurs following 0.1% to 0.5% of births, and typically begins within two weeks of delivery (Sit, Rothschild, & Wisner, 2006). Postpartum psychosis is characterised by delusions, hallucinations, disorganised behaviour, mood lability, depression and mania, and usually requires hospitalisation (Doucet, Jones, Letourneau, Dennis, & Blackmore, 2011).

2.2.4 Postpartum Depression as a Distinct Disorder

PPD is a complex, heterogeneous disorder, with wide variation in symptoms, severity and onset (Kettunen, Koistinen, & Hintikka, 2014). For many women, PPD represents a recurrence or continuation of a pre-existing mood disorder. In their review of 23 longitudinal studies, Vliegen, Casalin, and Luyten (2014) highlighted that for 38% of women included in the reviewed papers, PPD was a prelude to the development of a chronic depressive disorder. The authors noted however, that for some women this may be the continuation of a pre-existing chronic depression or dysthymia. Risk factors identified for chronicity of depression included; low quality partner relationship, history of depression, history of sexual abuse, low-quality maternal care, high parental stress, contextual risk factors and personality-related vulnerabilities. Overall, the existing evidence for PPD as a distinct disorder is not convincing (O'Hara & McCabe, 2013). In their review of the evidence, Di Florio and Meltzer-Brody (2015), concluded that PPD is likely to be a complex phenotype, encompassing several disorders with different disease pathways. The authors suggest that it is possible that for a sub-group of vulnerable women, childbirth triggers episodes of depression. However, even within this group, the mechanisms underpinning the mood disturbances are likely complex and heterogeneous. However, as noted by Di Florio and Meltzer-Brody (2015) and Brummelte and Galea (2016), it is important in both research and clinical practice, to distinguish between antenatal depression, postpartum depression and depression occurring at other times, as there are differences in the incidence, trajectory and outcome on child development, and potentially different requirements for treatment.

2.2.5 Diagnosis

Postpartum depression (PPD) is not recognised as a discrete diagnosis within the International Classification of Diseases, tenth edition (ICD-10, World Health Organisation, 1992) nor within the Diagnostic and Statistical Manual of Mental Disorders, fifth edition, (DSM-5, American Psychiatric Association, 2013). Rather, a diagnosis of Major Depressive Disorder (MDD) is indicated, with a specifier in DSM-5 of onset within pregnancy or within four weeks of delivery, and in ICD-10, a specifier of onset within six weeks of delivery is provided. However, within the literature and within clinical practice, the postpartum period is defined as within one year of delivery (Brummelte & Galea, 2016; O'Hara & McCabe, 2013). The term "maternal depression" has been suggested as a better descriptor of depression during pregnancy and in the first year after giving birth (Brummelte & Galea, 2016; Stuart-Parrigon & Stuart, 2014).

In conjunction with the DSM-V and ICD-10 diagnostic criteria, psychometric tests have also been developed to screen for the condition. The Edinburgh Postpartum Depression Scale (EPDS) (Cox, Holden, & Sagovsky, 1987) is by far the most widely used assessment instrument for PPD (Boyd, Le, & Somberg, 2005), with modest psychometric properties. The EPDS contains a number of items which assess anxiety symptoms, which as mentioned is a common feature of PPD. However, the EPDS does not include items relating to anger, obsessive-compulsive symptoms, stress or feeling overwhelmed, which are commonly experienced by women with PPD (Coates, Ayers, & de Visser, 2014; Kettunen et al., 2014).

2.2.6 Prevalence

Depression in the postpartum period is the most common complication of childbirth, affecting an estimated 13–19% of women worldwide (Gavin et al., 2005; O'Hara & Swain, 1996), with higher prevalence rates reported in low and middle income countries (Parsons, Young, Rochat,

Kringelbach, & Stein, 2011). Reported prevalence rates of postpartum depression are wide-ranging due to a number of factors, including; variation in the criteria for PPD, the method of assessment used (self-report or clinical assessment) and the period of time under consideration, for example within four weeks, six weeks, six months or one year postpartum (O'Hara & McCabe, 2013). O'Hara and Swain (1996) completed a meta-analysis of 59 studies from Europe, North America, Asia and Australia with a combined sample of 12,810, and found an overall prevalence rate of 13%. In Ireland, prevalence rates of 13.2% at six weeks postpartum and 9.8% at 12 weeks postpartum were reported by Leahy-Warren, McCarthy, and Corcoran (2011).

Evidence for increased risk of mood disturbance during the postpartum period is conflicting. van Bussel, Spitz, and Demyttenaere (2006) compared scores on the twelve item version of the General Health Questionnaire (GHQ-12) of 324 women before, during and after pregnancy with the scores at three corresponding time points of a control group of 324 women who had not given birth within the previous three years. The authors concluded that pregnant or postpartum women are not more at risk of mental health problems than non-postpartum women. However, the postpartum women included in the study were interviewed with the GHQ-12 three to six months postpartum. In an older, smaller scale study, Cox, Murray, and Chapman (1993) similarly found no difference in rates of mental health difficulties in women six months postpartum and non-postpartum women. However a spike in postpartum depression was detected within the first five weeks of delivery. Other research studies have identified an increased risk of depression in the postpartum period (Di Florio & Meltzer-Brody, 2015; Vesga-Lopez et al., 2008).

Despite the high prevalence of PPD and the reported difficulties with help-seeking (Dennis & Chung-Lee, 2006), screening for Postpartum depression is not currently carried out routinely (Glavin & Leahy-Warren, 2013).

2.2.7 Risk Factors for Postpartum Depression

Robertson, Grace, Wallington, and Stewart (2004), completed a meta-analysis of studies totalling 24,000 participants. They identified that the strongest predictors of postpartum depression are depression during pregnancy, anxiety during pregnancy, experiencing stressful life events during pregnancy or the early puerperium, low levels of social support, and a previous history of depression. Moderate predictors of postpartum depression are childcare stress, low self-esteem, maternal neuroticism and difficult infant temperament. Small predictors include obstetric and pregnancy complications, negative cognitive attributions, single marital status, poor relationship with partner and lower socioeconomic status including income. No relationship was found for ethnicity, maternal age, level of education, parity or gender of child. There has been some interesting research into biological risk factors which may affect a subgroup of women. In keeping with the biopsychosocial model of mental health, the biological, psychological and social risk factors of PPD will now be looked at in more detail.

2.2.7.1 Biological factors

The postpartum period is characterised by an abrupt decrease in hormones such as gonadal steroids and cortisol, which are elevated during pregnancy. These hormonal fluctuations have been posited to contribute to the development of postpartum blues and postpartum depression (Workman, Barha, & Galea, 2012). However, evidence for significant differences in hormonal fluctuations between women who develop postpartum depression and non-depressed women has been inconsistent (Workman et al., 2012). Empirical support for a hormonal sensitivity hypothesis is mounting (Workman et al., 2012). Similar to the sensitivity to menstrual hormonal fluctuations seen in women who experience premenstrual syndrome (PMS) and premenstrual dysmorphic disorder (PMDD) (Robinson & Ismail, 2015), it is proposed that a

subgroup of perinatal women experience mood-destabilising effects as a result of changes in gonadal steroid levels (Workman et al., 2012). This effect was illustrated in a small but innovative study by Bloch et al. (2000), in which the hormonal effects of pregnancy and childbirth were simulated on a smaller scale in sixteen euthymic women; eight with a history of postpartum depression but no history of nonpuerperal depression and eight matched controls with no history of psychiatric illness. Investigators manipulated the progesterone and estradiol levels in the women in three stages, under double blind conditions. Firstly hypogonadism was induced, supraphysiological levels of progesterone and estradiol were then added back for eight weeks to stimulate pregnancy, followed by a withdrawal of both steroids to mimic the hormonal effects of childbirth. Five of the eight women with a history of PPD and none of the eight women in the comparison group developed clinically significant affective symptoms during the withdrawal phase. Interestingly, the women with past experience of PPD reported depressive symptoms in the add-back (pregnancy) phase, with a peak in symptoms during the withdrawal (postpartum) phase. The authors conclude that these findings indicate that women with a history of postpartum depression may have a differential sensitivity to changing levels of estradiol and progesterone, which is not present in women without a history of postpartum depression. The results also suggest that symptoms of PPD emerge during pregnancy and peak in severity during the early postpartum period. This latter finding corroborates with existing studies suggesting that symptoms emerge in the prenatal period for one third of women who go on to develop PPD (Wisner et al., 2013), thus highlighting a huge opportunity for early intervention with this particular subgroup of women.

2.2.7.2 Psychological Risk Factors

Insecure maternal attachment style has been identified as a strong predictor of PPD (Ikeda, Hayashi, & Kamibeppu, 2014; Robakis et al., 2016), indeed a stronger predictor than history of psychopathology in the first three months postpartum. Aceti et al. (2012) also found an

increased prevalence of insecure (33.3%) and unresolved/disorganized (46.6%) attachment style in a clinical group of women with PPD, as measured by the Adult Attachment Interview, (AAI). The authors also reported that 66.6% of the mothers with PPD met the criteria for an Axis II disorder. Oddo-Sommerfeld, Hain, Louwen, and Schermelleh-Engel (2016) also identified personality disorder, specifically avoidant personality style, as a risk factor for postpartum depression, postpartum anxiety and mother-infant bonding impairment. Consistent with previous research (Gelabert et al., 2012; Mazzeo et al., 2006), the authors also found that dysfunctional perfectionism was a significant risk factor for PPD. As identified by Robertson et al (2004), higher levels of neuroticism (Dudek et al., 2014; L. Jones et al., 2010) and low self-esteem (L. Jones et al., 2010; Martini et al., 2015), have been found to be stable predictors of PPD.

Leahy-Warren, McCarthy, and Corcoran (2012) identified an association between PPD and low maternal parental self-efficacy. As pre-birth levels of self-efficacy were not assessed, the direction of the relationship is not clear; perhaps the depressive symptoms impacted on self-efficacy or perhaps negative self-beliefs contributed to the depression. Parental self-efficacy (PSE), refers to cognitions regarding one's ability and competence to parent (T. L. Jones & Prinz, 2005) and has been shown to be impacted upon by depression (Bandura, 1997).

2.2.7.3 Social Risk Factors

In an Irish sample of 410 first-time mothers, Leahy-Warren et al. (2012) identified lower levels of social support to be correlated with higher levels of postpartum depression. The authors provide some useful advice for community nurses, the professionals who have most contact with mothers in the postpartum period and are therefore in a prime position for detecting PPD and providing support or facilitating access to support (Glavin & Leahy-Warren, 2013).

Hahn-Holbrook and Haselton (2014), suggest that the shift from multigenerational families to smaller nuclear families might impact women's ability to cope with the demands of motherhood, thus contributing to depression. The authors point to a study (Campos et al., 2008), describing the 'Latina paradox' in which mothers who emigrate from Mexico to the United States experience lower rates of postpartum depression than European American mothers, despite their economic disadvantage and increased likelihood to be unmarried. The high degree of family and community support experienced by Latina women, compared with richer but more isolated European American women is believed to account for this paradox (Campos et al., 2008). In a longitudinal study of 210 women from diverse economic and ethnic backgrounds, Hahn-Holbrook, Dunkel Schetter, Arora, and Hobel (2013) identified that prenatal maternal family support, more so than support from the baby's father, acted as a buffer against increases in the stress hormone, placental corticotropin-releasing factor, in pregnancy, thus reducing the risk for postpartum depression.

2.2.8 Treatment for Postpartum Depression

2.2.8.1 Pharmacological Treatment

Pharmacological treatment of depression in postpartum period is more complex than treatment of depression at other times. Firstly, gonadal hormone levels in postpartum women may interact with efficacy of antidepressants (Brummelte & Galea, 2016). Also, antidepressant medication remains active in breast milk and could potentially affect child development (Brummelte & Galea, 2016). Thus many women are reluctant to take medication, resulting in poor treatment adherence (Turner, Sharp, Folkes, & Chew-Graham, 2008). In a systematic review, Molyneaux, Trevillion, and Howard (2015) concluded that, compared with a placebo, selective serotonin reuptake inhibitors (SSRIs) are associated with better response and remission rates

for postnatal depression. However, the authors noted that there was insufficient data to conclude whether antidepressants are associated with better outcomes than psychological interventions.

2.2.8.2 Psychological Treatments

The National Institute for Health and Clinical Excellence (NICE) guidelines recommend psychological interventions such as individual cognitive behaviour therapy (CBT) or interpersonal therapy (IPT) for women with PPD, in addition to, or instead of, antidepressant medication, depending on the patient's preference.

In terms of one-to-one psychotherapy, the strongest evidence base for treatment of PPD appears to be for Interpersonal psychotherapy (IPT), which is based on attachment and interpersonal theory (Stuart, 2012).

Although psychological interventions such as CBT and IPT are recommended for PPD, access to one-to-one treatment may be limited. Thus, group therapy may be a cost-effective and resource-effective alternative (Scope et al., 2013). In their systematic review of the literature, J. Goodman and Santangelo (2011) reported cautious support for the role of group therapy in the treatment of PPD. The authors highlighted gaps in the evidence base and implicated the need for further research. Of note however, statistical significant improvement in depressive symptoms was found in all but one of the eleven studies reviewed, despite considerable variability in the approach, orientation, format, duration and discipline of the facilitator of the groups. These findings suggest that support, in group format, facilitates the relief of PPD symptoms, independent of the approach or discipline of the facilitator. As Beck (2002), pointed out in her metasynthesis of the qualitative literature, attendance at postpartum depression support group helps alleviate feelings of isolation and loneliness, helps the women realise they are not alone and creates hope.

2.2.8.3 Maternal-Infant Treatments

Research into the impact of interventions into PPD and maternal-infant relationship have indicated that interventions aimed at improving mother-infant interactions do not necessarily lead to improvements in maternal depression (Cooper et al., 2009; Nylen, Moran, Franklin, & O'Hara, 2006). Likewise, psychological interventions to improve maternal depressive symptoms have not been shown to improve maternal-infant relationship (Gunlicks & Weissman, 2008). Overall, the research suggests, treatment for depression in the postpartum period should target the mother-infant relationship in addition to the mother's depressive symptoms (Brummelte & Galea, 2016; Forman et al., 2007).

2.2.8.4 Preventative Interventions

In a meta-analysis of a wide range of interventions to prevent PPD, Sockol, Epperson, and Barber (2013) identified a significant reduction in depressive symptoms and depressive episodes. The interventions included therapy, modified care, social support, antidepressant medication, educational programs, dietary supplements, and hormonal interventions. Interestingly, similar to findings reported above by J. Goodman and Santangelo (2011) the authors reported that intervention type was not related to the effectiveness of treatments for either reducing depressive symptoms or preventing depressive episodes. It may be that nonspecific, social contact and support, is sufficient for reducing risk for depression among this population, and that the specific active elements of treatment are less important.

A Cochrane review completed by Dennis and Dowswell (2013), similarly found a clear beneficial effect in the prevention of postpartum depression for a range of psychosocial and psychological interventions. The authors identified support for professionally-based postpartum home visits, lay or peer based postpartum telephone support, and interpersonal

psychotherapy. Interventions provided by various health professionals and lay individuals were similarly beneficial.

2.2.8.5 Barriers to Treatment

In a systematic review of 40 qualitative articles incorporating a diverse demographic, Dennis and Chung-Lee (2006) identified a number of salient barriers to help-seeking. These included, difficulties in opening up about their depressive symptoms due to shame, stigma, fear of losing their baby, beliefs that they should deal with it alone and not wanting to burden their family members. In addition, women expressed a preference for "talking therapies" with a non-judgemental person over pharmacological interventions.

2.3 Qualitative Studies of Postpartum Depression

Qualitative research has contributed greatly to our understanding of women's lived experience of postpartum depression.

In a seminal paper on PPD, Beck (2002) identifies four over-arching themes associated with the lived experience of postpartum depression, derived from a metasynthesis of 18 qualitative studies published during the 1990's. These four themes include; Incongruity between expectations and reality of motherhood, Spiralling downward, Pervasive loss and Making gains. The themes identified by Beck (2002) will be discussed in detail here, with reference to more current qualitative literature, which advocated the same themes, including two recent meta-syntheses (Knudson-Martin & Silverstein, 2009; Mollard, 2014). Additional findings outside of Beck's four themes will then be discussed.

Incongruity between expectations and reality of motherhood

The painful disparity experienced by many women between the reality of motherhood and their dreams and expectations, is a theme which pervades the qualitative literature on postpartum depression (Barr, 2008; Buultjens & Liamputtong, 2007; Hall, 2006; Homewood, Tweed, Cree, & Crossley, 2009; Knudson-Martin & Silverstein, 2009; Patel, Wittkowski, Fox, & Wieck, 2013). In a more recent metasynthesis of 12 qualitative studies, Mollard (2014) also identified this theme as prevalent across all of the studies, labelling it as "Crushed Maternal Role Expectation". First time mothers experienced guilt and shame when they did not live up to their idealised expectation of what a "good mother" should be. Parity was found to influence the nature of the conflict experienced by women, with first time mothers experiencing guilt for not living up to the image of "the perfect mother", while multipara failed to live up to their expectations of being able to cope with their newest child (Mauthner, 1998)

Spiralling downward

Beck's description of the downward spiral of postpartum depression encompasses a range of emotions including; anxiety, anger and feeling overwhelmed. In addition, women with PPD experienced obsessive thinking and cognitive impairment. Feeling isolated and guilty, many contemplated taking their own lives. In Mollard's (2014) meta-synthesis, she includes an over-arching theme, which she entitles "intense vulnerability". This incorporates feelings of anxiety and needing to be cared for, which is a part of the downward spiral and a need emerging from the downward spiral.

Pervasive Loss

In a powerful description, Beck states that *"loss permeated deep into the crevices of depressed mothers' lives. It insidiously seeped into the very fibre of their beings."* p.466.

This loss, also evident in more recent literature, is conceptualised by Beck as a loss of control over thought processes and emotions. In addition, loss of autonomy, loss of sense of self, loss of their former relationships and loss of their voice was also experienced by many women included in the meta-synthesis (Chen, Wang, Chung, Tseng, & Chou, 2006; Lawler & Sinclair, 2003). Mollard conceptualises the loss of self as an overarching theme in her meta-synthesis. She includes feelings of depersonalization and detachment from reality and from caring for the baby within this theme. Mollard conceptualised "the fog of depression", as part of the loss of self, even though this is not perhaps evident from the original studies (Amankwaa, 2003).

Making Gains

Beck states that recovery for many mothers first involved "surrendering" and admitting they needed help. This was identified as a tremendous hurdle to overcome due to the shame and stigma associated with PPD (Hall, 2006; Knudson-Martin & Silverstein, 2009). Many women experienced a poor response to their help-seeking and felt minimised or ignored. Beck noted that for many women in the studies included in her review, they found support and hope by attending a support group. This has been noted in more recent qualitative studies (Hall, 2006; Hanley & Long, 2006). Re-adjusting their expectations and accepting the loss of their former selves was cited as part of the journey to recovery.

Other themes not included in Beck's meta-synthesis

In Mollard's (2014) metasynthesis she includes a theme entitled "practical life concerns", which incorporated additional factors which may relate to PPD, such as, lack of sleep and fatigue, pain of postpartum recovery, work and money concerns, demands of housework, cooking and caring for their children, health concern and strain on their relationship with their partner. The title of this theme is perhaps unfortunate, as it minimises the impact of these concerns. Referring to them as "practical" concerns, suggests they are everyday and reasonable

concerns. For many women these issues may not be a concern. However, for women with postnatal depression, who are consumed by guilt and self-blame, the demand of caring for their babies, cooking and cleaning while sleep deprived, highlights how often the expectations on mothers are too high. In a qualitative study, exploring women's subjective experiences of first time motherhood from a feminist perspective, Choi, Henshaw, Baker, and Tree (2005) highlighted that women feel that they should be able to cope with, not only caring for a new baby, but also with domestic tasks and the caring of others. The authors argue that this reflects the cultural representations of femininity today, which are of a "superwoman", able to cope with so many competing demands. In Hanley and Long's (2006) qualitative study of ten Welsh women, which was not included in Mollard's review, they also identify the theme of feeling overwhelmed by childcare and household duties. However, they contextualise this finding, by referencing how the social structure of the family has changed significantly over the past twenty years, and how many mothers identified that they had limited support from their own mothers, who were still in employment. As identified by Chen et al. (2006), the social and cultural context in which the experience of PPD occurs, cannot be ignored or minimised, nor can the extent that these influences will have on the expectations and pressures that many women experience.

Knudson-Martain & Silverstein (2009) reported that their metasynthesis confirmed Beck's four overarching themes. They added to the literature by suggesting that it is the experience of isolation from others, as a result of an inability to disclose the emotions and experience of PPD, in a validating context, which supports and maintains the depression. The authors propose a relational model of PPD and assert that recovery from PPD requires reconnection with others.

Beck's influential, cornerstone paper, provides eloquent descriptions of the lived experience of postpartum depression, giving a collective voice, and a shared narrative, to the women who have first-hard experience of PPD, and who are often silenced by the dominant quantitative

research. The generalisability of Beck's themes is evident from their continued presence in the available qualitative literature up to the present day. A number of limitations to Beck's study were identified, which were not outlined within the paper. The inclusion criteria for Beck's metasynthesis was papers in which (a) the focus was postpartum depression and (b) the research design was qualitative. Postpartum depression was defined as a nonpsychotic depression episode that starts in, or extends into, the postpartum depression. This definition allows for the inclusion of women whose depression predated their pregnancy, thus potentially obscuring the narrative emerging from the experience of depression with perinatal onset and its distinctive features. In addition, there was no requirement for the participants to have received a formal diagnosis. Within some of the studies reviewed, PPD diagnosis was based on self-report (Mauthner, 1998). Also, it is unclear from Beck's paper whether the women who participated in the 18 studies included in her metasynthesis were currently depressed or not. Review of the original papers revealed a mixture of participants who were currently experiencing postpartum depression and participants who had recovered (Beck, 1996; Mauthner, 1998). Furthermore, reflecting the lack of diversity in qualitative studies into PPD at that time, all of the papers reviewed in Beck's metasynthesis were based on women living in Western society. Finally, some papers included in the study broadly explored women's experiences of negative affect in the postpartum period rather than looking specifically at PPD (Nicolson, 1999).

It is worth noting that, in carrying out a metasynthesis, the author analyses the analysis of the researchers included in their review, which, it could be argued, has the potential to slightly diminish the voice of the individual participant. However, metasyntheses are particularly useful in adding to our knowledge base of a phenomenon like PDD, which has been heavily explored qualitatively. By drawing together the rich findings to compile a large narrative of the shared experience of PPD, the collective voices of women who have experienced the condition, can

inform the way in which measures are designed and the way in which PPD is viewed, assessed and treated.

2.3.1 Postpartum depression and mother-infant relationship

Very few qualitative studies focused specifically on women's experience of their relationship with their baby and other children during PPD. However, a number of articles refer to this experience within one of their themes.

Beck (1996) completed a phenomenological study investigating the meaning of postpartum depressed mothers' experiences interacting with their children. Although this paper is old, it is worth citing briefly, as it provides some valuable insights into women's own perspectives on their relationship with their children during PPD. Beck reported that the twelve mothers she interviewed, experienced guilt, irrational thinking, loss, anger and felt overwhelmed by the responsibility of caring for their children. The mothers reportedly went through the motions of caring for their infants, erecting a wall to separate themselves emotionally, consequently failing to respond to their infant's cues. Despite their distress, the mothers made attempts to put their children's needs first and protect them from their depression.

Some more recent studies include the experience of the relationship as a subtheme within their qualitative studies of PPD (Barr, 2008; Coates et al., 2014; Hall, 2006). For example, Barr (2006) completed a phenomenological hermeneutic study of eleven women currently experiencing PPD. One of Barr's themes is "mechanical infant caregiving". Under this theme, the author describes how some of the women interviewed, struggled to find a sense of love for their newborns and carried out duties such as changing nappies in an automatic, non-thinking manner, which she calls "mechanical infant caring". The author states that *"All participants at the time the data was collected were all actively undertaking infant care, regardless of the lack of maternal–infant attachment"* (p. 366). However, the author did not formally assess mother

to infant attachment. The lack of connection and love described by the mothers in her study is probably more aptly referred to as bonding. Bonding and attachment are two different concepts which are unfortunately often used interchangeably in lay, and indeed professional discourse, which is misleading (Bicking & Hupcey, 2013). Furthermore, within Barr's study, she provides a quote from a mother, describing her feelings towards her baby;

"You don't care about the baby, oh you meet her needs like changing a nappy and things and you focus on her. It's like a primal love. An instinct. An instinct to protect, to nurture, to look after this baby. We bath and we read. Boy do we read! I can't read all the time but when I can, I do… I feel I have to learn how to do this [mothering]. That is my job."

It is not possible to assess mother-infant attachment from a quote like this however, the idea of a primal, instinctual love, speaks more to the concept of attachment, which is a biologically based, goal-corrected behavioural system in which the mother sensitively attunes and regulates her infant. In contrast, maternal-infant bond refers to the strong maternal feelings of love towards one's infant, which perhaps this mother feels she is missing.

2.4 Postpartum Depression and Attachment

2.4.1 Attachment Theory

The concept of the attachment system was introduced by John Bowlby (1969), to describe the biological, evolutionary process by which infants instinctively seek proximity and comfort from their caregiver when distressed. Bowlby proposed that when the caregiver, in most instances the mother, is consistently attuned and responsive to the child's needs for safety, security and nurturance, the child will develop a secure emotional attachment, recognising their

caregiver as a secure base from which they can explore the world. Through repeated activation, and regulation of their attachment system, children develop what Bowlby described as an internal working model of attachment. These internal working models serve as cognitive relationship templates for themselves, their mother (or primary caregiver) and their relationships with others. Of note, Bowlby suggested that attachment status is established over four phases within the first three years of life. From 0 – 3 months, infants exhibit behaviours such as making eye contact, crying, smiling and babbling to draw attention and signal their needs. Bowlby proposed at that at this stage the infant's attachment behaviours are indiscriminate. From 3 – 6 months, infants become more directed in their attachment behaviours and are less responsive to unfamiliar people. The third phase, aged 6 – 24 months, marks the emergence of goal directed attachment behaviours such as seeking proximity, following and clinging to caregivers, who they regard as their safe base, particularly when their attachment system is activated at times of e.g. fear, tiredness, hunger, or illness. Stranger anxiety and separation anxiety are also evident at this stage. In the fourth phase, 24 months and beyond, children have established internal working models of their attachment relationships. This internal working model becomes the blueprint from which an individual references within their future significant relationships.

Mary Ainsworth and colleagues further developed Bowlby's ground-breaking theory of attachment, by identifying three patterns of mother-infant attachment which can be measured in a simple laboratory procedure, known as The Strange Situation. In their monumental text, *Patterns of Attachment*, Ainsworth, Blehar, Waters, and Wall (1978) describe the classification of infant-mother attachment, based on observation of the infant's reaction to the reunion with their mother, or primary caregiver, following a brief, experimentally contrived separation. These attachment styles develop as a consequence of the mother or primary caregiver's responses to their infant's affective states and attachment behaviours. The most common and

most healthy attachment style is Type B, secure attachment. During the Strange Situation assessment, which is considered the gold standard measure of infant attachment classification, infants with a secure attachment seek proximity to their mother on reunion, openly communicate their feelings of distress, are easily soothed by their mother and readily return to exploration. Development of a secure attachment is facilitated when a mother or primary care giver, consistently responds to the infant in a sensitive and timely manner. Two forms of insecure attachment were identified by Ainsworth and colleagues. Type A, insecure/avoidant attachment style and Type C insecure/ambivalent. Children with a Type A, insecure/avoidant attachment style do not seem distressed on separation from their mother and actively avoid and resist their mother when reunited or in any situation when their attachment system is activated. Children develop an insecure-avoidant attachment style when their mother is insensitive, rejecting, or ignoring of their attachment behaviours. Children with insecure-ambivalent attachment style, will approach their mother when reunited i.e. when their attachment system is activated, however they are difficult to soothe. This attachment style manifests when a primary caregiver is inconsistent in responding to the infant's attachment behaviours.

Secure, avoidant, and ambivalent attachment patterns are considered "organized" because they represent an infant's adaptations to their primary caregiver which maximizes their access to care and proximity. Main and Solomon (1990), proposed a fourth attachment style, Type D, disorganised attachment style. Disorganised attachment often develops in cases of abuse, neglect or unresolved maternal trauma (Hesse & Main, 2006). When the child is faced with the paradoxical situation in which the source of safety and comfort is simultaneously the source of fear, they cannot develop an organised approach or strategy to deal with stressful situations. Children with a disorganised attachment display contradictory and inexplicable behaviour in the Strange Situation paradigm, sometimes a combination of Type A and Type C strategies. Children with disorganised attachment, represent a particularly at risk group for future

psychopathology (Fearon, Bakermans-Kranenburg, Van Ijzendoorn, Lapsley, & Roisman, 2010).

Thus, a vital role of the attachment figure, typically the mother, is to regulate her infant's fear and distress. However, when the mother is in a state of fear or distress herself, her capacity to fulfil this role is compromised.

Adult Attachment Style

As highlighted, Bowlby conceptualised attachment as a lifespan concept which provides a blueprint for future relationships. Bowlby (1979), predicted that a parent's own attachment experiences and representations would influence the quality of their caregiving.

Adult attachment style can be assessed using the Adult Attachment Interview (AAI) (George, Kaplan, & Main, 1985). Adults are classified as secure/autonomous, insecure/dismissing, insecure/preoccupied, or unresolved/disorganised, based on the coherence and organisation of their responses to questions regarding their past attachment relationships (Hesse, 2008). Secure/autonomous adults tend to value attachment relationships, describe their attachment experiences (whether positive or negative) coherently, and consider them important for their own personality. Adults with an insecure/dismissing attachment style tend to minimize the importance of attachment for their own lives or to idealize their childhood experiences, without being able to provide concrete illustrations. Individuals with an insecure/preoccupied attachment style tend to maximize the impact of attachment. They remain involved and preoccupied with their past experiences and are unable to describe them coherently and reflectively. An unresolved/disorganised attachment style is evident in adults who demonstrate incoherent, unresolved representations of past experiences involving loss, trauma or abuse (Bakermans-Kranenburg & van Ijzendoorn, 2009). Numerous studies have documented the power of the AAI to predict the quality of the individual's relationships with significant others

but also to predict parenting and subsequent infant–parent attachment (Bakermans-Kranenburg & van Ijzendoorn, 2009).

In what is often referred to as the "transgenerational transmission of attachment", multiple studies have demonstrated that a mother's capacity to regulate and sensitively respond to her infant's need for comfort, proximity and safety, is associated with her capacity to regulate and organize her own thoughts and feelings about her primary attachment relationship (Slade, Grienenberger, Bernbach, Levy, & Locker, 2005). Despite considerable research and significant progress since Bowlby and Ainsworth's revolutionary publications, the exact mechanisms underlying the intergenerational transmission of attachment remains somewhat elusive (Slade et al 2005; Beebe et al 2010). As these underlying mechanisms hold the key to understanding the pathway from maternal depression to infant attachment, they will be discussed in further detail.

2.4.2 Intergenerational transmission of attachment

A number of studies have shown that infants of mothers experiencing depression are at increased risk of forming an insecure or disorganised attachment (S. H. Goodman et al., 2011). The negative impact of postpartum depression on infant attachment has been shown to persist even when the mother has recovered (Righetti-Veltema, Bousquet, & Manzano, 2003). Research investigating the mechanisms of the relationship between PPD and attachment have identified a number of factors which may contribute to the disruption of mother-infant attachment.

Maternal sensitivity to infant distress has been identified as one of, but not the only factor, which contributes to secure infant attachment (Bakermans-Kranenburg, Van Ijzendoorn, & Juffer, 2003; McElwain & Booth-LaForce, 2006; Wolff & Ijzendoorn, 1997). Cognitive

distortions associated with depression, have been shown to impact on maternal sensitivity to infant behaviour Trapolini, Ungerer, and McMahon (2008).

Parental reflective functioning, which refers to the capacity of parents to interpret the mental states of their child and consider how their mental states affect their behaviour has also been associated with secure infant attachment (Slade et al., 2005). This reflective capacity may be reduced in mothers with PPD, thus potentially impacting on sensitivity.

The capacity to reflect on the infant's mental state and respond sensitively, is key in affect attunement, a precursor to affect regulation. Daniel Stern (1985), developed the concept of affect attunement, describing it as, *"the acts and processes that let other people know that you are feeling something very like what they are feeling"*, (p. 138). A mother attunes to her infant's affect by communicating that she understands how they are feeling, in a process known as *"cross-modal attunement"* (Stern, 1985). This intersubjective exchange of affect involves three processes. Firstly, the mother must read the infant's feeling state through observation of their overt behaviour. Secondly, the mother must perform a behaviour that is not a strict imitation of the infant's but corresponds in some way. This might include a maternal movement that matches the pitch, rhythm or intensity of the infant's vocalisations. Thirdly the infant must be able to perceive this maternal response as connected to their feeling experience (Stern, 1985). This interaction brings a sense of vitality and enjoyment to the in tune dyad. In contrast, Stern proposed that missattunement or non-attunement can occur, for example, when the mother is severely depressed, in which there is a lack of awareness of the infant's affect and intention or a lack of capacity to engage with the baby (Stern, 1985).

In their research on infants of depressed mothers, Tronick and Reck (2009) used video techniques to study the micro-analytic, second-by-second organisation of the emotional communication between infants and mothers during face-to-face interactions. These authors

used these microanalytic techniques to function as a temporal microscope, revealing the distortions of the infant-mother communication system and their effects on infants. Firstly, the researchers demonstrated that maternal-infant attumement is not perfect, and is characterised by a series of mismatches, with synchronised affect happening only a small portion of the time. The researchers highlight the "messiness" of normal interactions, an imperfect dance from mismatching to matching, generating positive and negative affect. Echoing Winnicott's (1960) concept of "good enough" mothering, Tronick and Reck highlight the importance of these episodes of misscoordination and repair, for giving the infant a sense of security in the belief that they can overcome challenges and rely on their mother. In contrast, repeated mismatches, without repair, contribute to an accumulation of negative affect, which has a negative impact on infant-maternal attachment.

Maternal depression has also been associated with less warmth, smiling, vocal and visual communications, affectionate touch and reduced levels of play (Field, 2010; Lefkovics, Baji, & Rigó, 2014). This negative impact of depression on mother-infant interactions has been related to negative outcomes for long term cognitive development (Parsons et al., 2011), with male infants found to be more vulnerable to the effects (Grace, Evindar, & Stewart, 2003; Tronick & Reck, 2009). However, the impact of PPD on child cognitive developement has been difficult to differentiate from other contextual risk factors and the effects of chronic depression (Grace et al., 2003).

Overall, maternal depression has been described as resulting in either hostile or withdrawn maternal behaviour, which may adversely impact on attachment (Field, 2010; Lefkovics et al., 2014). In turn, infants of depressed mothers have been observed to be more withdrawn and display less positive effect during face to face interactions with their mothers (Murray, Fiori-Cowley, Hooper, & Cooper, 1996).

In their seminal article, "ghosts in the nursery" Selma Fraiberg and colleagues (1975), outlined how a mother's past experience could influence her capacity to provide warmth and attunement to her infant. A mother with unresolved trauma related to attachment may display what Main and Hesse (1990), describe as frightened or frightening dissociative behaviours, which are parallel to the usual reactions to intense fear or stress; fight, flight or freeze, (Guedeney et al., 2011).

Una McCluskey's research into affect attunement in adult psychotherapy led her to develop the concept of "goal-corrected empathetic attunement" (GCEA), within the attachment system, (McCluskey, 2011). Bowlby described how, when an infant's attachment system is activated by fear, it will impact on the infant's exploratory behaviours, unless their fear is regulated by their attachment figure. Likewise, in her work on the attachment dynamic between the therapist and client, McCluskey identified that, when a caregiver's (therapist) fear system is activated, their ability to attune and provide fear-free empathetic caregiving to their client is compromised. This concept is noteworthy for its potential relevance to the experience of fear in the maternal-infant attachment relationship.

Therefore, maternal depression can cause impairment in any the above outlined factors which contribute to attachment, resulting in a detrimental impact on maternal-infant attachment. Conversely, these factors which contribute to maternal-infant attachment, can also act as a buffer, or in a protective capacity, if they remain intact despite maternal depression. This may explain some interesting findings from a number of review papers and a large scale Dutch study. These findings suggest that not all infants of mothers with depression have an insecure attachment. Furthermore, as highlighted by a number of review papers (Lefkovics et al., 2014; Wan & Green, 2009), the evidence of negative effects on attachment is not clear-cut. The

degree of symptom severity, chronicity of depression, and mother's pattern of behaviour is likely to influence the quality of attachment. Wan and Green, (2009) report that there is little evidence overall that depression limited to the postnatal period, has a direct, long-term impact on child attachment and subsequent developmental trajectories. The authors state that their review highlights that most children whose mothers have mental health problems, do not develop lasting attachment difficulties. Indeed, the authors argue that the deterministic view that maternal depression necessarily leads to disorganised/insecure attachment, is not only empirically unfounded, but also stigmatises these parents, and impedes help-seeking in those cases where attachment is a concern.

In a well-powered Dutch study of 627 low risk, infant-mother dyads in the general population, Tharner et al. (2011), found no association between postnatal depressive symptoms, as measured by the EPDS at two months postpartum and insecure infant attachment, as measured by the Strange Situation assessment at 14 months. These findings are in contrast to previous studies with smaller, low-risk samples, (Righetti-Veltema et al., 2003). The authors propose a number of explanations for their interesting findings. Firstly, it is possible that the non-clinical levels of depressive symptoms, which occurred in the low-risk sample, were not invasive enough to affect the infant-mother attachment relationship. The most consistent correlations between maternal depression and infant attachment insecurity, have been in high risk or clinical samples, in which other strong environmental factors such as poverty exist. Therefore, it is possible that only severe, or chronic maternal depression, impacts on the mechanisms underlying the association with mother-infant attachment. It is also conceivable, that the impact of other risk factors in high-risk samples may amplify the effect of maternal depressive symptoms, such as social support, education level, and family income. The authors highlight the possible presence of moderating protective factors within the low-risk sample, such as maternal attachment representation. The authors concluded that further research is required to

identify which protective factors moderate the potentially detrimental effects of PPD on the infant-mother attachment in the general population.

As suggested by Tharner et al. (2011), one potential protective factor is maternal attachment style. Mothers with postnatal depression are more likely to have an insecure adult attachment style (Wilkinson & Mulcahy, 2010). However, McMahon, Barnett, Kowalenko, and Tennant (2006) found that for mothers with a secure adult attachment style, their depression did not have a detrimental effect on their infant's attachment. This research was not specifically focused on postpartum depression. Similarly, Iyengar, Kim, Martinez, Fonagy, and Strathearn (2014) provided empirical validation for Fraiberg and Main's findings by reporting that mothers with unresolved trauma had insecure attachment themselves, and were more likely to have infants with insecure attachment. However, the authors reported that mothers with unresolved trauma, who were reorganising towards secure attachment, had infants with secure attachments. Thus, these preliminary findings suggest that reorganisation of attachment may lead to more sensitive caregiving and secure infant attachment.

Another potentially significant moderating factor is parental reflective functioning (Slade, 2005). Although the research on the role of parental reflective functioning in attachment is in it's infancy, it holds some promise as a potential buffer against the detrimental impact of maternal depression on maternal-infant attachment (Slade et al., 2005). Fonagy and Target (2005) suggest that mothers with high reflective functioning have greater ability to regulate their babies fear. The concept of parental reflective functioning has been linked to Bion's (1962) concept of containment and Stern's concept of affect attunement (Fonagy & Target, 2005). With reference to reflective functioning and contingent mirroring, Fonagy states; *"In markedness we deny what we feel while at the same time maintaining our individuality. In effect, we become what the child needs us to be"* (Wallin, 2006, p. 49). This notion echoes idea of Winnicott (1971) *"giving back to the baby, the baby's own self".* In theory, if a mother can

respond to her infant in a way that is congruent with the infant's emotions, then perhaps the mother's own internal state may not impact on the infant's attachment.

Within the existing literature, two unpublished thesis (Vrieze, 2011; Wong, 2012), have explored reflective functioning as a protective factor. Both studies found that reflective functioning was not correlated with depressive symptoms. The later study found that reflective functioning moderated the relationship between depression and attachment.

Recent studies have also supported the importance of protective factors such as parenting quality, sensitive responsiveness, maternal state of mind, and partner's support (Lefkovics et al., 2014).

The majority of studies into the impact of maternal mental health and child development have focused on depression in the nonpostpartum period (Lefkovics et al., 2014). Although inferences can be made, depression in the postpartum for 40% of women, represents a first episode (Wisner et al., 2013) with unique features (Brummelte & Galea, 2016). Despite the fact that the direct pathway between PPD and infant attachment remains unclear, it is reasonable to conclude that maternal postpartum depression represents a significant risk factor for infant attachment outcomes and more information is needed to clarify this process. This research will qualitatively explore women's experience of postpartum depression and their relationship with their baby at the time, which may shed some light on the lived experience of this process.

2.5 Rationale for the current study

As evident from the literature review, there is a wealth of qualitative and quantitative research into postpartum depression. However, considering the increasing prevalence, the poor rates of treatment and the long-term negative effects of postpartum depression on children's health and

social, emotional, cognitive and physical development, the need for continued research attention on the topic is apparent (Dennis & Chung-Lee, 2006; Field, 2010).

Although there have been substantial qualitative studies completed on PPD, the majority of studies have been completed with women who are currently experiencing an episode of postpartum depression. In addition, there is a dearth of studies with women reflecting on their experience of caring for the baby during their PPD. As outlined above, the majority of studies exploring this particular aspect of PPD were quite descriptive. Through Interpretative Phenomenological Analysis, the current research will add an interpretative context to the literature base.

The aim of the current study was to qualitatively explore the experience of postpartum depression and the mother-infant relationship, with women who have recovered from PPD. The following specific research questions were explored:

- How do women who have recovered from PPD make sense of their experience of PPD?
- How did their PPD impact on their relationship with their baby?
- What helped these women to get through this difficult time? And what else (if anything) would have helped?

CHAPTER 3: METHODOLOGY

3.1 Chapter Introduction

This chapter firstly provides a rationale for the qualitative methodology chosen, followed by a description of Interpretative Phenomenological Analysis (IPA). Information on the participants, procedure and ethical considerations is also provided. Finally, a detailed description of the data analysis is outlined, reliability and validity considerations are discussed and reflections on the research process are considered.

3.2 Rationale for the methodology

A qualitative methodology was chosen as the most appropriate paradigm to fit the aforementioned research questions. Qualitative research is a form of social enquiry which seeks to explore the meaning individuals attach to their subjective experiences and the world in which they live.

Postpartum depression and the mother-infant relationship has been explored widely in the quantitative literature, and to a lesser extent in the qualitative literature. However, as outlined above, there remain gaps in terms of service provision, help-seeking, engagement with services and our overall understanding of the phenomenon, and particularly of the nature of the mother-infant relationship during this time. Qualitative research plays an essential role in enhancing clinical knowledge, by capturing the meaning people attach to particular phenomena (Collingridge & Gantt, 2008). The phenomenological philosopher Edmund Husserl famously urged phenomenological researchers to "go back to the things themselves" (Smith, Flowers, & Larkin, 2009). Husserl argued that our predilection for order, causes us to prematurely fit

'things' into our pre-conceived categories. In essence, this research sought, as Husserl suggested, to go back to the phenomenon of PPD and caring for an infant during this time, and to explore the lived experience of this phenomenon with women who have come through it.

Furthermore, it has traditionally been argued by feminist researchers that quantitative research is context-stripping by nature and as a result, the reality of the human, and particularly the women's experience is lost (Bohan, 1992). A qualitative methodology, particularly with the use of open-ended interviewing, allows the voices of women to be heard, which are often silenced by the medical model and dominant quantitative research paradigm.

Interpretative Phenomenological Analysis (IPA) (Smith et al., 2009), was identified as the most appropriate qualitative method to explore the research questions. Other qualitative methodologies, such as grounded theory were considered. However, as the research question was not concerned with developing a new theory of PPD or of the mother-infant relationship during PPD, grounded theory was not considered appropriate. The current study was interested in gaining an insight into a mother's lived experience of postpartum depression and forming a relationship with their baby during this time, with consideration of the wider social, cultural and psychological context. IPA was deemed to be the approach which facilitated this endeavour.

The philosophical foundations of IPA stem from phenomenology, hermeneutics and idiography (Smith et al., 2009). The phenomenological component of IPA refers to the study of human experience, particularly things that matter to us and that which constitutes our lived world (Smith et al.,2009). IPA interviewing encourages the participant to adopt a reflexive mode and direct their gaze inwards toward their perception of their experience, thus evoking what phenomenological philosopher Husserl describes as the "phenomenological attitude" (Smith et al., 2009). Within the IPA framework, the researcher's interpretation of the

participant's perception of their reality is important. This is referred to as the double hermeneutic or dual interpretation process. The idiographic orientation within IPA refers to the in-depth analysis of single cases, examining the individual's perspectives in their unique context (Pietkiewicz & Smith, 2014), before cautiously moving to an examination of similarities and differences across cases, so producing "*fine-grained accounts of patterns of meaning for participants reflecting upon a shared experience"* (Smith et al. 2009, p38). Thus, IPA is suitable for detailed, nuanced analysis of small samples, such as the current study, providing rich information on individual cases as well as overarching themes relating to the shared experience.

3.3 Participants

A purposive criterion sample of 8 women, aged between 33 and 44, participated in the current study. The inclusion criteria for the sample was; women, aged 18 and over, who had experienced postpartum depression in the past and who were not currently depressed. Participants were recruited through Nurture, a registered charity which provides nationwide counselling and support services for women who are experiencing a pregnancy and childbirth related maternal mental illness.

Women who met the criteria and expressed an interest in participating, were provided with an information sheet, (Appendix A) and their contact details were passed on to the researcher by a counsellor within Nurture who acted as a gatekeeper. The participants were then contacted by the researcher by phone to gain verbal consent, provide further information if needed, and schedule the interview. Written informed consent (Appendix B) was obtained on meeting, prior to the interview commencing.

Table 1 illustrates information on the participants including age, number of children, treatment received and prior history of mental health problems. All women lived with a male partner or husband.

Table 1: Characteristics of the sample

Participant Number	Participant Psudonym	Age	Parity	Treatment received	History of mental health problems (self-report)
1	Mary	36	3	1-1 Psychotherapy Group therapy/support Medication	No
2	Niamh	44	2	1-1 Psychotherapy Group therapy/support Medication Admission to psychiatric hospital	No
3	Paula	39	3	1-1 Psychotherapy Medication	Yes
4	Margaret	34	1	1-1 Psychotherapy Medication	No
5	Liz	38	2	1-1 Psychotherapy Group therapy/support	No
6	Emma	40	3	1-1 Psychotherapy Group therapy/support Medication	Yes
7	Chloe	33	1	None	Yes
8	Ann	35	3	Group therapy/support Medication Admission to psychiatric hospital	No

3.4 Procedure

Participants were recruited as outlined above, and one-to-one, face-to-face interviews took place at a venue of the participant's choice; their home, or a room in Nurture headquarters. Interviews lasted between 40 minutes and 1 hour 10 minutes and were audio recorded on an

‘Olympus Dictation’ app. on a password-protected, Apple iPhone 6. The audio recordings were uploaded to the researcher’s password-protected laptop immediately after each interview and the original recording was deleted. Interviews were transcribed verbatim by the researcher.

On meeting the participant, a couple of minutes were spent building rapport. The participant was afforded the opportunity to ask any questions, and were provided with the informed consent form to sign after reading it (Appendix B).

A short interview schedule (Appendix D), was prepared by the researcher, and used as a guide during interviews, as recommended by Smith & Osborn, (2007) . In keeping with the inductive stance of IPA (Smith et al., 2009), the researcher allowed the interview to be led by the interviewee, with the interview schedule used as a loose boundary. Considering the sensitivity of the topic under exploration, and the emotionality experienced by the participants when recalling painful memories, the noninterventionist stance of an IPA interview was appropriate, using general open questions and gentle prompting (Smith, 2004). The three main interview questions were:

- Tell me about your experience of postnatal depression?
- Tell me about your experience of caring for your baby during this time?
- What helped/would have helped you get through this difficult time?

The researcher made reflective notes after each interview to capture the immediate impressions, thoughts, feelings and process of the interview. These notes, (see Appendix G for an example), were useful in the analysis of the data.

3.5 Ethical Considerations

Ethical approval was sought and granted by the University of Limerick Education and Health Sciences Research Ethics Committee, (See Appendix E). The application process was guided by the Psychological Society of Ireland (2011), Code of Professional Ethics and assisted the researcher in considering ethical issues which may arise over the course of the research.

It was acknowledged from the outset, that women who have experienced postpartum depression in the past represent a vulnerable group. A number of potential risks were identified, and procedures to minimise the risk were put in place;

- The interviews involved asking participants to talk about a difficult time in their lives. Participants were informed in the information sheet, (Appendix A) prior to participating, that the interview would focus on their experience of postpartum depression and on their relationship with their child/children.
- Written consent was sought from participants prior to the interview commencing (Appendix B) and they were reminded that they could withdraw at any stage.
- It was anticipated that participants might become tearful and emotional while discussing this sensitive and emotive topic. On these occasions, the researcher used her clinical skills to deal with any upset sensitively, while maintaining the researcher-participant boundaries. A plan was in place that, should the participant become emotionally distressed beyond what would be experienced in their everyday life, or should an episode of undiagnosed depression or other mental health difficulty become evident, support and/or therapy would be provided by a Nurture Counsellor.
- The researcher allowed time at the end of the interview to debrief and check in with the participant about how they were feeling, and the impact of the interview on them.

Contact details of the researcher and supervisor, Nurture and other support organisations were provided in a debriefing sheet, (Appendix C).

A number of measures were taken to ensure participant confidentiality was protected;

- Interviews were audio recorded on a dictaphone app on a password protected iphone.
- After the interview, the audio recordings were transferred onto a password protected laptop and deleted from the iphone.
- Interviews were transcribed and anonymised onto an encrypted word document on the password protected laptop and the original audio recordings were deleted from the laptop.
- Anonymised transcripts were held by the researcher (lead investigator) and shared only with the supervisor (principal investigator) for the purpose of inter-rater reliability at the analysis stage.

Although it was not the purpose of the research, it was hoped that the respect, appreciation and value placed on their opinions and experiences, might bring the participants a sense of satisfaction and empowerment, in the knowledge that their contribution was helping to advance our understanding of postpartum depression and attachment, which may have implications for future interventions. Indeed, some participants commented after the interview that they found talking about their experiences to be cathartic and all women expressed a desire to help other women through their participation. All participants were given a €10 gift voucher in a thank you card as a gesture of appreciation for their valuable time and contribution.

3.6 Data Analysis

In keeping with the idiographic paradigm of IPA, each interview was analysed following the steps outlined below, based on guidelines provided by Smith et al. (2009).

Step 1: Reading and re-reading

After the interviews were transcribed verbatim, the researcher read and re-read the transcripts a number of times, initially while listening to the audio, and later while imagining the voice of the participant in subsequent readings. The researcher's own initial impressions, thoughts, emotional reactions and overall sense of the interview was noted in a reflective journal (See excerpt in Appendix).

Step 2: Initial Noting

The transcripts were reformatted into the structure recommended by Smith et al. (2009). The transcribed interview was inserted into the middle column of a three-column table. The column to the right of the text was used for noting exploratory comments and the column to the left for emerging themes, (Appendix F).

A free textual analysis was initially conducted, to produce a comprehensive and detailed commentary on the interview. This close analysis was lengthy and conducted over the course of a number of months. In keeping with the iterative process of IPA, the comments were layered as the researcher read and re-read the transcript.

Appendix F illustrates an excerpt of the script from this stage of the analysis process. The descriptive comments, seen in normal font, are phenomenologically focused, capturing the thoughts, feelings, experiences, values, and relationships described explicitly by the participant. Linguistic comments, seen in italics in Appendix F, are words, phrases, gestures, pauses, smiles or laughs extracted from the transcript, which provide key insights into the lived

experience of the participant. Interpretive comments, which were underlined, represent a progression to a more conceptual level of commenting. These comments built upon the descriptive and linguistic comments following multiple analysis of each transcript. As advocated by Smith et al. (2009), utilising the double hermeneutic approach, the researcher drew upon her knowledge of the literature, psychological theories and her clinical and personal experience to reach a deeper level of interpretive understanding of the participant's lived experience. Other analytic techniques used included, de-contextualisation of the transcript by reading the text backwards, sentence by sentence, and free association with certain powerful linguistic sections of text (Smith et al., 2009). Smith et al. (2009) encourage creativity in approaching the analysis. Other linguistic techniques used by the researcher included searching for synonyms for powerful words used by participants to get a deeper insight into how the use of that word paints a picture of their experience, e.g. 'empowering', 'dogmatic', 'cocoon', 'lulled'. The researcher also used Microsoft Word to find the frequency of certain words used, e.g. impossible, should, and words associated with fear.

Step 3: Developing emergent themes

At this stage, the focus of the analysis shifted from the original transcript to the large volume of exploratory comments. Emergent themes were identified, which are pithy statements reflecting the psychological essence of a particular section in the context of the entire text. The themes identified are both grounded in the original transcript and conceptual, reflecting the double hermeneutic approach.

Step 4: Identifying connections across emergent themes

This stage involved mapping of themes which fit together, while keeping the research questions in mind. Some themes were put aside at this point, to be reconsidered in light of emerging themes in subsequent transcripts. A number of techniques were used to identify patterns and

overarching themes which illustrated the most important and interesting aspects of the participant's account. The techniques used included; physical arrangement of themes, numeration using Microsoft Excel and word clouds using NVivo software (See Appendix H for examples from this stage of the analytical process).

Step 5: Moving to the next case

These four steps were repeated for each case. Attempts were made to "bracket off" themes identified in previous cases in order to maintain the idiographic commitment and view each case on its own merit. This step was challenging, as themes and ideas which concurred with previous interviews, tended to 'jump out' at the researcher. In a way, this forced the researcher to really engage with each line and segment of the transcript and exploratory comments, in order to avoid missing an important idiosyncratic theme.

Step 6: Looking for patterns across cases

Finally, a meta analysis was completed of all of the themes across all 8 interviews. Similar methods to those used to identify connections across emergent themes in individual cases as outlined in step 4, were used to identify super-ordinate themes across all cases. All themes were written out on a large piece of paper and numbered in terms of which cases they arose. These themes were transferred to a Mind Map using XMind 7 software, to provide a clean visual of all of the themes, (Appendix H). Many maps and tables were drafted before a final set of superordinate and subordinate themes were devised, (Appendix H).

3.7 Reliability and Validity Considerations

Unlike quantitative research, qualitative research is not focused on falsification of theory and the search for one truth (Pietkiewicz & Smith, 2014). The epistemological stance in qualitative

research is concerned with meaning making, and the quality of experience rather than causal relationships. Reliability and validity are equally important in qualitative research, however they must be measured in different ways (Collingridge & Gantt, 2008).

In quantitative research, reliability is concerned with the extent to which the research findings can be replicated. IPA research is concerned with the idiographic lived experience and the researcher's interpretation of this, without necessarily seeking to generalise the findings. Thus, another researcher replicating the study may not reach the exact same conclusions. Instead, qualitative research achieves reliability by ensuring the credibility, confirmability, dependability and transferability of the results (Lincoln & Guba, 1985).

A number of strategies were used to ensure this standard was maintained in the current research. The research supervisor conducted mini-audits by looking at the 'paper-trail' of data analysis (Mays & Pope, 2000). The supervisor looked at transcripts with initial coding and exploratory comments, to check for fidelity to the approach, and credibility of the interpretative claims made in relation to the original transcripts. The supervisor also offered his own comments, thus developing the analytical skills of the researcher. The researcher also liaised with another trainee clinical psychologist who completed multiple coding on a section of anonymised transcript. This additional coding was incorporated into the analysis. Furthermore, the researcher discussed the findings with an independent IPA research consultant who also reviewed the write-up of the analysis to ensure fidelity to the IPA approach.

Validity refers to the extent to which the research measures what it set out to measure. In the current study, the research questions were made explicit in section 2.5. Smith et al (2009) advocate the use of Lucy Yardley's framework for ensuring validity and quality in qualitative, IPA research (Yardley, 2008). This framework was applied throughout the research to ensure validity and commitment to the research questions. This criteria involves four broad principles;

sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance.

In terms of sensitivity to context, IPA was adopted as the most appropriate methodology for exploring the lived experience of postpartum depression and attachment. Interviews were conducted with sensitivity to the participant's emotional reactions to discussing often painful memories. The interview was facilitated by the researcher in an open style, to allow free-flowing, intensive discussion of the phenomenon, eliciting experientially vibrant accounts, while allowing the participant to protect herself from becoming overwhelmed by changing the direction of the discussion. At times, the researcher took steps to contain the participant's upset by moving the focus of the interview from the past to the present.

As regards commitment and rigour, the researcher read widely on the IPA approach and its philosophical underpinnings and adhered to the guidelines provided by Smith et al. (2009) in gathering and analysing the data, which was obtained from a reasonably homogenous sample recruited through a charity focused on maternal mental health.

Transparency and coherence were demonstrated in the adherence to the IPA approach and its idiographic, phenomenological and hermeneutic underpinnings. The researcher endeavoured to follow these principles by providing an explicit description of how the research was conducted, supported by illustrations of various stages of the process in the appendices.

Finally, in terms of impact and importance, the researcher believes this thesis will contribute to the research literature and service provision, for women experiencing postpartum depression and their children.

3.8 Reflection on the research process and researches position

As regards the analysis, the philosophical underpinnings of IPA methodology appealed to me. I believe the double hermeneutic approach fits nicely with how we are trained as clinical psychologists; to see the world through the eyes of our clients, reflecting on our own experiential knowledge and psychological theories to interpret what the person in front of us is experiencing. I believe it acknowledges and values the knowledge and experience of the researcher, while at the same time recognising the participant as the expert in their own lives. I believe it is a very humanistic approach. As the hermeneutic theorist Schleiermacher wrote "*everyone carries a minimum of everyone else within themselves"* (1998 p.92-93). This reminds me of one of my favourite quotes by Harry Stack Sullivan *"we are all much more simply human than otherwise"* (Sullivan, 1953). Such a philosophical position is appropriate in the investigation of an often stigmatised topic such as postpartum depression and attachment. IPA moves away from psychiatric or psychological reductionism to view the person in a holistic manner, sharing what they chose to share about their personal experience of the phenomenon of postpartum depression.

On a personal level, I began this research project after the birth of my son. As a first time mother, I was interested in the topic of infant mental health. As I began reading widely on the topic, one of the things which struck me was the myriad of ways in which parents, and particularly mothers as the primary care-giver, can have such a detrimental impact on their child's development. As a new mother, I felt the weight of that responsibility. I was struck by how little information there seemed to be on how some women can go through difficult times such as postpartum depression or anxiety with little obvious impact on their children. I began to wonder what the protective factors were. I also began looking for qualitative accounts from women themselves about their experience of the attachment relationship during this time and

as indicated in the literature review, there were not many studies specifically looking at this. Therefore, my research questions developed from this.

As I conducted the analysis, I was mindful of my interest in these protective factors and of the need to bracket off my own assumptions in order to let the data speak for itself. I was conscious that in some cases, there may not have been any protective factors, that the impact on the relationship may have been devastating and irreparable, and if so, that needed to be heard too.

Although luckily I never suffered from postpartum depression, I could certainly identify with some of the women's stories in terms of the lack of sleep, the desire to be the perfect mother, the worry and the constant second-guessing of oneself. As a mother of a toddler, I also found it difficult to hear some of the stories, particularly when the mothers, due to their distress, could not attune or be available emotionally to their children. I was aware of the need to remain empathetic, professional and non-judgmental. I was also aware that, as difficult as it was for me to hear, it was only a fraction of how difficult it must be for them to think and talk about. It was difficult to sit with the distress at times as it was not a therapeutic space. I found myself working to containing my own emotions as a mother and a woman feeling sadness and anger at times on hearing the women's stories and about how they were treated, or not treated as the case may be. The use of reflective journaling throughout the research process, was valuable in noting my observations, assumptions and reactions to the data, and how this influenced my analysis.

CHAPTER 4: RESULTS

4.1 Chapter Introduction

This chapter will present the results of the Interpretative Phenomenological Analysis (IPA) of interviews with eight women about their past experienced of postpartum depression and caring for their baby during this time. The analysis revealed a number of subordinate themes with three overarching, superordinate themes, summarised in Table 2. A description of each theme is provided, illustrated by excerpts from the interviews.

Table 2: Superordinate and Subordinate Themes

Superordinate Themes	Subordinate Themes
Feeling Inadequate	Perceptions of Motherhood
	Shame of Feeling Inadequate
	Downward Spiral
Fear-Filled Caregiver	Fear system Activated
	Attachment System Activated
	Attachment to Baby
Journey to Recovery	Problem Located Within the Mother
	Lack of Containment
	Recovery Through Connection and Acceptance
	Regret and Loss

4. 2 Overview of the Superordinate Themes

Table 2 presents the superordinate and subordinate themes which emerged from the data. 'Feeling Inadequate' refers to the negative views of themselves as a mother, held by the participants during their episode of PPD. Perceived failures led to feelings of guilt, shame and inadequacy which contributed to and sustained their depression. The 'Fear-Filled Caregiver' refers to the theme of fear which was identifiable in many interviews. The ways in which this fear manifested and the potential impact on the mother-infant attachment is explored. In addition, attempts made by the mothers to protect their baby from their PPD are discussed. The final superordinate theme, 'Journey to Recovery', concerns the growth and development of the participants in the process of overcoming their PPD, and the factors which promote and impede recovery.

4.3 Superordinate Theme 1: Feeling Inadequate

The 'Feeling Inadequate' superordinate theme encapsulates the lived experience of postpartum depression as narrated by these eight women and their internal representations of themselves as a 'bad mother'. Measuring themselves against unrealistic standards, self-imposed and endorsed by their external environment, the women experienced feelings of guilt and shame for their perceived inadequacies which maintained the classic 'downward spiral' of postpartum depression.

> *"I felt like I, I just couldn't do it. I was just, like that's probably the main thing, that I just kept on thinking I was a bad mother."*
>
> Chloe

4.3.1 Perceptions of motherhood

Six out of eight of the women interviewed indicated unrealistic expectations of themselves as a mother. Both first and second time mothers held expectations of how they 'should' think, feel and behave, extending from pregnancy, to childbirth, to motherhood.

Chloe, a mother of two, speaks about how she did not experience the instant rush of love and emotional connection to either of her babies that she had expected, and had been led to believe, she would feel.

> *"people were like, oh yea when you go into labour and it is amazing when they hand you your baby and you have this big feeling of love, and I just felt like I missed out on all that, that I didn't get that. That I kind of had to, not, kind of had to learn to love them, they were new little people to me..like obviously I did really love them, but for me to actually properly fall in love with them I had to kind of get to know them."*
>
> Chloe

She also experienced disappointment with the experience of childbirth, identifying how her hopes and dreams of what it would be like were dashed.

> *"I just kind of felt like I was cheated out of (laughs), like this wonderful feeling of like being able to push your own baby out and everything like that…because like I had all these ideas in my head…none of it went to plan. Absolutely none of it. I couldn't handle the pain, I was in an awful mess… I was just, I was so unrealistic about what actually happens when you go into labour."*
>
> Chloe

Ann, described in her interview a deep feeling of love for her twins. However, in a pattern which was evident in a number of women's narratives, her desire to be the very best mother

for her babies, led her to place unrealistic expectations on herself, and resulted in feelings of inadequacy and a belief that she wasn't good enough, which impacted on her ability to fully attune to her babies.

> *"when they used to cry, like, I didn't know what to do, I was saying, you know why, why am I their mother? A mother should be able to do everything for them, a mother should know what's wrong with them, know how to soothe them, you know…I was more kind of putting pressure on myself as well… I should have been the perfect mother, I should have been able to do absolutely everything for them"*
>
> Ann

The unrealistic expectations were perpetuated by the healthcare system, society and culture which expects mothers to give endlessly to their children, even when it is at the expense of their own mental health. In the example below, Niamh describes how she tried to voice a desire to discontinue expressing for her premature twins due to impact it was having on her physical and mental health.

> *"I asked about stopping expressing because I just was exhausted. I was told I couldn't…that they wouldn't tolerate formula...and I began to say, but I'm really, I don't think this is going well, I'm exhausted I'm anxious all the time and I was blocked the whole way"*
>
> Niamh

This example highlights how maternal mental health is sometimes ignored by the healthcare system. The mother's voice is silenced, with no acknowledgement of her ownership of her body, her babies and her choice. This mentality reinforces disempowerment and feelings of inadequacy and failure.

All of the women interviewed alluded to comparing themselves unfavourably to other mothers; strangers, friends and family members, who all appeared to be doing better than they were. Thus, the women reported feeling inadequate, feeling as though they were failing, when they believed they were not able to meet the same standards as other women.

> *"you see other people and they always look really smart and they'd be like happy out with their two kids or three kids going around, you kind of felt like I was failing, like I just couldn't do it"*
>
> Chloe

> *"You get into a, I suppose a spiral, and the more you kind of look at comparing yourself to other people, you always find yourself wanting, you always find that other people that you perceive have more business having issues than you do are coping so much better"*
>
> Mary

It was identified by many of the mothers, that once they spoke to other women about their feelings and their experience of PPD, many of the women they spoke to admitted to experiencing similar feelings, albeit not necessarily to the extent of clinical depression. This highlights how difficult it is in our culture and society for women to admit to these feelings and to be open about the reality of motherhood, thus maintaining the façade of the perfect mother. In this way, the unrealistic expectations were also perpetuated by other women.

> *"it's only when you do actually talk to people, like my friends and stuff, like I told them all like what I was going through and they were saying like, they're exactly the same."*
>
> Chloe

4.3.2 Shame of Feeling Inadequate

Many of the women, with the help of societal and cultural expectations, set themselves up for disappointment and feelings of failure, by setting unrealistic standards. Feelings of shame associated with not being good enough was a strong theme across many of the interviews.

> *"I had these standards that I had set for myself that I would never ever reach. And then I would feel angry with myself and feel very very useless, because I didn't meet this unreachable expectation."*
>
> Paula

> *"Other people can do it, I just couldn't, and I just got so sick. (tearful) And it took me a hell of a long time to even say that…because I think the shame associated with being a mother and not being able to do it is very tough (crying)…the shame was huge (crying, pause) and I think I lost any view of myself being competent"*
>
> Niamh

A vicious cycle emerged of attempting to meet unrealistic standards, giving too much of oneself, then failing to meet these standards. Thus, triggering self-blame and self-criticism, contributing to shame, further depression and an erosion of self-confidence.

> *"it was my fault again, you know so, be blaming myself, my fault I can't cope, my fault I can't feed him, my fault you know, my fault I had 3 boys, my fault so it was all you know, my fault I can't get a child minder it was all me, me, me, me, and there was nobody else"*
>
> Emma

"you feel nothing that your doing is right, but yet your trying to do everything for everybody, you obviously forget completely about yourself"

Mary

This cycle became a self-fulfilling prophesy, as some of the mothers experienced difficulty attuning to and being emotionally available to their children, thereby providing more reasons for self-blame. The excerpts below highlight how feelings of inadequacy and shame, impacted on how the women felt about and interacted with their babies.

"I knew there was a bond there, that I loved him, but I just felt he deserved someone better, better than me, because no matter what I did I couldn't seem to make him happy or you know, or get in a routine"

Liz

"*I didn't feel good enough, I didn't have any energy and I felt like I couldn't bond with my kids. Not that I didn't love them or anything else, I just felt like I couldn't bond with them."*

Ann

"I always say, the quicker you get help so you don't have evidence building up and up and up and up how shit you are or how much of a job you're not doing".

Paula

Many of the women experienced anger towards themselves and self-hatred for not being good enough.

"I had hatred for myself, I had em it was all self-blame. I didn't look after myself, I didn't wash em I lost the best part of 2 stone, eh (pause) yeah it wasn't a nice time at

all…when the tears came jaysus the tears came and they'd last for days, days and days."

Emma

This self-blame cycle contributed to and maintained the downward spiral of depression.

4.3.3 Downward Spiral

The 'downward spiral' is referenced by a number of women in this study and echoes throughout the qualitative literature on postpartum depression. This downward spiral incorporates a loss of identity and confidence, a feeling of being overwhelmed, angry and out of control. The women described feeling lonely and isolated, as though they were the only ones feeling this way. Cognitive distortions were also experienced by the women during the depressive episode, which maintained their depression.

All of the women interviewed reported feeling overwhelmed and as though they could not cope with the demands of being a mother to their children during their PPD.

"I was crying, I was screaming, I wasn't coping, I wasn't thinking, I wasn't eating, I couldn't make decisions. Em, everything just got on top of me, I never thought I could cope"

Paula

"It was like, I knew I loved them, I knew I loved them deep, you know deep down I knew I loved them but I just found it so overwhelming, I was very resentful of their father being able to go out and work and I was left on my own at home trying to mind the 2 of them."

Ann

A number of women interviewed reported strong feelings of anger. They felt extremely overwhelmed and angry with themselves for not being good enough. Anger and sadness were often intertwined in the narratives of these women, for some, anger was their primary emotion, for others it was sadness, which was manifested as anger. Often supressed emotions, constant self-criticism and feelings of inadequacy spilled out and were expressed as frustration and anger.

> *"I was very angry at the time, anxious and very angry, you know, anything would go wrong and I wouldn't have the patience I would just be, my temper was, I'd have to walk away and you know the fear that (pause) yeah anger was a big one as well"*
>
> Liz

> *"The final thing that made me realise or admit to myself was em my anger. My anger towards him as a toddler, and seeing him everyday cry because of shit that I was talking or how I was talking to him or whatever. But I knew I was very very sad. But that manifested as anger for me because that anger would be more empowering."*
>
> Paula

All of the women alluded to cognitive distortions associated with depression, which left them feeling like they were "*not in my own mind*". They described being in a *'fog'* and reflectively described thinking styles which were rigid, black and white and irrational at times.

> *"I'd say my perception and my thinking was very warped, was very off centre"*
>
> Paula

These cognitive distortions described by the women, highlight the importance of a retrospective study in which participants can reflect on their experiences with the clarity of good mental health.

"now that I'm kind of through it, through the fog of it all"

Mary

Many of the women identified a loss of their sense of self associated with the transition to motherhood and the decline of their mental health.

Paula, a mother of three children, who experienced PPD after her first and second baby, described how she lost her identity to such an extent that she was unrecognisable to herself.

"to be honest all I ever had, right, was my mental health. So I would have been always very very strong. I would have been always quite resilient. I would have been quite courageous about things…So it was always something that always stood to me…So I em, found when I didn't have that, kind of felt that I was nothing… I felt you know that everything I knew, or that I stood for or who I was was gone."

Paula

She later says, in relation to her interactions with her son, *"I just thought, oh my god, what have I become",* conveying the shame and disappointment felt towards herself as a mother. When describing her own experience of the downward spiral she says, *"I didn't know myself".*

Her internal working model of herself as a person, and as someone of value was shattered. Niamh described a similar experience; her identity as a competent, high-achiever, who worked hard and made a living helping others was shattered, when she was confronted with the terror she experienced trying to care for her premature twins.

"It was probably the first time in my life I came across something that I wanted to do but I couldn't…and that belief system, everything just came crashing down…and that if anything I'd say led to the depression as well as the complete lack of sleep"

Niamh

Margaret described a similar experience of losing her sense of self and her confidence in herself.

"It was the total opposite of me, like I wasn't myself at all"

"I'm quite a confident person like in general and I wouldn't, it's not like me to suffer from panic attacks or anything like that or people feel sorry for me and stuff like that"

Margaret

For Margaret, her unplanned pregnancy resulted in a loss of her identity, freedom and the life she enjoyed. For her, this forfeiture was exchanged for a life of fear, rather than the joyful emotional connection and loving attachment, which may typically be almost a trade-off for this loss of former self and freedom experienced by many women.

"I never got to grips with actually having a baby, like I never thought it was real, like it changed me and then I kind of didn't want to be a mam. I didn't plan it. Em, it's not that I didn't love her I just felt like I wanted my own life back."

Margaret

Sleep deprivation was identified by six out of eight of the women as a factor which exacerbated their symptoms.

"…just absolutely exhausted, I'll never forget that tiredness…like he'd be awake 2 or 3 times a night, some nights I'd be downstairs for 4 hours…and then you were up the next morning to get her ready…and when you're not in your right frame of mind yourself it's even more, you're just, you're lying in the bed and you don't want to get out of the bed…or you're lying there waiting for him, knowing he's going to wake up"

Liz

"I kept saying if I could just get more sleep, if I could get more sleep, but the problem was, even when there were people here to help, I couldn't sleep. Em and if I did sleep I would wake up with such terror and dread and I would go back into the cycle, if I could just give them up, if I could just give them away"

Niamh

As articulated here, for some of the mothers, even when they had the opportunity to sleep, they found they were unable to do so, due to the inner turmoil they were experiencing.

"Like my mam came up and took the kids loads of times and I, just, because I was just so wound up that I just couldn't sleep. I'd sit upstairs and I'd be like, everything would just irritate me… And then I'd feel like I am after failing because my mam had to go and take my kids"

Chloe

The downward spiral of PPD can be conceptualised as a gradual deterioration in the mother's mental health. For some, whose experience of PPD might be considered mild to moderate, their recovery happened midway or early on in the spiral. Unfortunately, for others they reached dangerous levels of depression before the journey to recovery began. Four of the women interviewed reported experiencing suicidal ideation during their PPD.

"I had tried to commit suicide at that stage. Em because nothing was working and I thought I was better off, better off away from everything, they'd be better off without me, so that was the first time I tried it"

Emma

Liz recalled the poignant moment when, feeling overwhelmed and having lost all confidence in herself as a mother, she said goodbye to her son, with the intention of going to take her own life.

> *"I'm not the right mammy for you and it's not cause I don't love you but don't worry your new mammy is going to come and look after you but I'm not going to be here anymore"*
>
> Liz

4.4 Superordinate Theme 2: Fear-Filled Caregiver

The "Fear-Filled Caregiver" was a prominent theme across all of the interviews in various forms. The mothers experienced fear in their relationships with their children, which appeared to impact on their ability to attune to their infant's cues. Many of the women, aware of the potential impact of their depression on their babies, attempted to hide their feelings from the baby or protect them in other ways. The experience of giving birth, for many women prompted the emergence of core beliefs about themselves and their relationships. The experience of motherhood and the experience of fear both activate the attachment system, thus any pre-existing insecurities become exposed.

4.4.1. Fear system Activated

Fear was a theme which emerged strongly throughout many of the interviews. For some of the women, trauma such as a miscarriage, a traumatic birth, or the risk of losing their baby, activated their fear system following childbirth. For these women, their fear was often rational to begin with, but when left uncontained, generalised beyond the triggering event leaving them in constant fear.

"I…became terrified, absolutely terrified of everything."

Niamh

"I was convinced they would die…that was the underlying piece, they are going to, they are going to starve and they are going to die."

Niamh

Four of the women interviewed had experienced previous trauma of losing a baby. Their fear was activated during their pregnancy and birth. Uncontained, they remained hyper-aroused. For them, it was not safe to bond with their baby. Even after the baby arrived safely, or was out of the risky period, they could not let their guard down. Their fear generalised to all situations, impacting on their relationship with their baby.

Margaret, who had two previous miscarriages, one quite late in pregnancy, describes how she did not feel safe from the moment she found out she was pregnant and this fear remained after delivery.

"I never felt safe… everything happens so quick and your whole body is in shock you know and then I was left on my own in the dark with this little baby and terrified like"

Margaret

"I always felt like I was so happy to have her but yet resentful of her that I don't have my own life, my body changed, my whole life changed and (boyfriend) got to do, like his life doesn't change at all but it's you and like I was just like trapped. Trapped in my body, trapped in my mind, trapped in this house, trapped with her, I just felt I couldn't get out and having a cigarette out the back was just my way of escaping"

Margaret

The fear experienced by some of the mothers activated their fight, flight and freeze response. In the quote above, Margaret describes her natural response to feeling trapped, which was to escape. This can be conceptualised as a flight response. She sought to give her baby up for adoption but when this was not an option, she withdrew into freeze mode. She felt numb and unable to emotionally connect with her baby.

> *"I was always worried, like I just could never relax and enjoy it you know.. I started getting panic attacks and I didn't want to be on my own with the baby… I felt mentally trapped"*

Margaret

Niamh also experienced a fear so strong that she felt she needed to escape, by any means.

> *"I began to beg (husband) to let me put them up for adoption. (Pause, tearful)… it began to really, really take root and it became the only solution for me. And then when I was getting, everybody was saying no, understandably, what I began to think was, well maybe if I didn't wake up (pause)…Or maybe if they didn't wake up (Pause, very tearful)."*

Niamh

On reflection, Paula identified that her response to fear was to go into 'fight mode'.

> *"It was easier to survive, everyday when you are angry…and your all, you know fight mode. That's really what I was and that's, that's real animalistic brain isn't it, that's real raw, look just survive everyday"*

Paula

A number of the women described living in constant fear. Liz, below describes fear so strong it was palpable.

> *"There was days I couldn't leave the house. There was days that I, it was like a brick wall in front of the front door, absolutely terrified me to walk out the front door."*

Liz

4.4.2 Attachment System Activated (core beliefs emerge)

In the excerpt below, Paula reflects that "core issues just resurface after you become a mother". In this statement, Paula very insightfully captures the way in which a woman's attachment system becomes activated when she becomes a mother. This can cause old attachment related wounds to emerge, such as abandonment. For many women, they experienced fear and intense vulnerability. Negative self-beliefs, appeared to impact on their view of themselves as a mother and on their relationship with their baby.

> *"I had a huge standard, of a mother, of what a mother would be because my own mother, in my mind was rubbish. And she would have left our home when I was 11…"*

> *"And you know there's no surer time for all that stuff to come up.. I think…that is one of the biggest things, that core issues just resurface after you become a mother."*

Paula

In the following example, Margaret indicates feeling rejected by her baby, recalling how her baby would cry when Margaret's own mother handed her back. For Margaret, she needed to keep an emotional distance from her baby in order to protect herself from this rejection.

"She'd go over to me and she'd start crying and I'm like, she just obviously prefers you anyway"

Margaret

"I just kind of feel that, not that I didn't want her but I felt I didn't deserve her or something like that"

Margaret

For some women including Margaret, their own attachment history and attachment style appeared to play out in their relationship with their baby. Margaret, who has a history of abandonment by her father, and subsequently by her step father, describes being quite independent and confident prior to having her baby. She had supressed her emotions following two miscarriages but these unprocessed feelings, along with her own experience of being parented, emerged when she became a mother herself.

"I moved out of my house like, I moved out when I was about 17 and I just went to college and I got a job then and I never lived with my mam then after that so we weren't really that close and I wouldn't really talk to her that much…I definitely think that, my two other brothers that we're all very, not like damaged from what happened but like my mam had it tough and she was like a single mam and we lived in a council house for years until like she met someone and then they bought a house and then they split up because he had an affair, that was tough, we were teenagers at that stage and I just wanted to get away"

Margaret

Margaret attended counselling and found it helpful to *"get up the older feelings from years ago"* as she had never dealt with her feelings following her two miscarriages, the second of which occurred when she was six months pregnant.

> *"I never kind of grieved for it or I never.. em kind of let it affect me like I just went on normally afterwards"*
>
> Margaret

Margaret identified that, although medication was useful, in her case, her depression was linked to core issues therefore the effectiveness of the medical model alone was limited.

> *"I don't know if the tablets are the way to go, like what do they do, if it's from like let's say we might have the same issue of growing up and really struggling and stuff that like how is a tablet going to fix that?"*
>
> Margaret

Chloe also identified core feelings of inadequacy which impacted on her relationship with her husband and contributed to feelings of not being good enough for her children.

> *"it's just a horrible feeling to always kind of, be looking for reassurance all the time that I am doing a good job…between that and reassurance that (husband) still loves me and like it's nearly that sometimes I feel like I am nearly pushing him away, to kind of prove to myself like, oh I was right, I knew he didn't fancy me anymore".*
>
> Chloe

For other women, family rules and expectations impacted on their ability to speak out, and deal with their emotions following childbirth. Two of the women who kept their depression hidden from their families, spoke about their home environment which indicated that expressed emotion was not the norm.

"(youngest) was nearly 3 when I told my own mam…and at that I told her in a letter I didn't even tell her face to face because I couldn't… I got a letter back saying that she still loved me, that her and my dad still loved me and that she was sorry that I went through all that on my own, more or less that was it. Now it would have been very hard to her to write that I know that cause, my mam wouldn't have been an emotional person at all"

Emma

"My dad pronounces, says one day, em you know if your mother was around, I don't think she would have understood you. She never had time for women with postnatal depression (laughing) and my world came crashing down, yeah no she never, her idea was pick yourself up and get on, what's wrong with you, and I was like oh so harsh"

Liz

4.4.3 Mother to Infant Attachment

The experience of fear, and the experience of being a mother, activates the attachment system. For many of the mothers, when their own attachment needs were not met, their fear was not contained or regulated. This appeared to impact on their ability to be emotionally available to their baby and their ability to respond to their attachment behaviours. Niamh describes how her anxiety prevented her from responding to her son's needs.

"he wanted to be fed more and I got very much into, no it must be routine, I have to have some idea what I'm doing, I need to have routine. And so when he would cry before the routine told me he was going to cry, that started to boost me up even more."

Niamh

Liz articulates how she felt unworthy and inadequate. Her rigid thinking associated with her depression would not allow her to attune to her baby and his needs.

> *"I suppose when you're in your right mind you kind of realise, well there're different children, whereas at that stage I couldn't understand why he wasn't like his sister, why he wasn't routine in his bottle"*
>
> Liz

This focus on routine was also reported by other women, which may be interpreted as difficulty attuning to the baby's needs due to anxiety. Society also reinforces and influences this viewpoint. Babies, like mothers, are judged as good or bad, depending on how well they fit into adult's routines.

> *"I remember in Super Value when he was a baby and he was screaming, and this woman said to me, ah what's wrong with him is he a good baby?, and I went, no he's a nightmare, and she was like (gasp), oh my god, oh right and left and I said well don't ask the question if you don't want an honest answer ...people just want you to go, oh yeah he's great, sleeps through the night, has his feed, in a routine, aw brilliant basically you know"*
>
> Liz

In an overlap with the expectations versus reality theme, Chloe explains how she expected to feel in pregnancy and how she did not feel bonded to her baby until a few months after he was born. Chloe had two miscarriages prior to the birth of her second child, at which point she developed postpartum depression. For Chloe, having experienced two miscarriages, it would not have felt safe to bond in pregnancy.

"For me, I always had it in my head that you, you get pregnant, you have this amazing, because even when I was pregnant I didn't feel attached…I knew there was a baby growing and everything and I thought everything was amazing and but I didn't have that, like I do hear women say like, oh I am so in love with my bump, and this and that, like to me it was just like, ok I am growing a baby but I don't know this baby, yet…I don't know whether I sound quite heartless but…you know the way, it's just I didn't, I didn't attach myself…I kind of feel guilty about that"

Chloe

These feelings are associated with a huge amount of shame. In the course of the interviews, it was apparent that the experience of caring for their baby and their feelings towards their baby during their PPD, was the most difficult and most painful memory to recall for all of the mothers. For most of the women interviewed, they shared what they could, and then moved away from the memories before they became overwhelmed by them.

"I'd never say it to anybody, I haven't even said that to (Husband), I just wouldn't, because it is one of those things, as a mother you aren't supposed to feel like that...and to actually think that you are not attached to your own child is a horrible feeling."

Chloe

"you do pay a huge price and it's something that's a real taboo subject. A mother doesn't want to say, I am feeling this way because, what am I going to do to my child. And they're terrified. I didn't realise I was terrified. Because I was in survival brain. My child would be identical to that. He is just still in survival brain I think."

Paula

"when they'd smile I'd cry, (tearful) crying that they were happy and that I couldn't (pause) sorry (crying)"

Ann

In the excerpt above, Ann begins to talk about a memory of being unable to attune to her babies' happy interactions due to her depression. This was a very painful memory, which she was unable to continue to speak about.

It is worth noting that the words 'bond' or 'attachment' were never used by the researcher. The questions about how the participants' felt about their baby, and how they experienced their relationship during PPD prompted participants to reflect on their feelings of attachment to their baby at the time. Some of the mothers were painfully aware of the potential for attachment difficulties and made efforts to protect their babies.

"I still have a fear that I have knocked, knocked, like left my mark on them"

Emma

"You always think how it's going to affect the kids or how it has affected them and not come out yet"

Mary

Some of the mothers pretended, in order to protect their children, however they wondered whether it was 'enough'.

"I was trying to be super interested in everything they did and you know super with them all the time, I don't know how they would perceive how detached I was at that stage."

Mary

"there was times where I did feel I pretended to be a mother…where you put on this role, because that's what it is. Em but I did it because, you know the potential for attachment difficulties"

Paula

Ann, who had no professional or personal support, attempted to protect her children from her depression by hiring a childminder to help her at home and sometimes sending them to a crèche. However, she experienced a lot of shame for this, she also experienced judgement from others.

"I used to pay somebody to come in and help me mind the twins and that made me feel worse, the fact that, no mother wants to feel like they need help… I felt like a bad mother, I felt like I was so incapable of looking after my own kids… I remember a few people like, oh my god you know, you're not looking after the twins, you know, you have them in a crèche?? It's like they're voicing out like, you're a bad mother like, you can't even look after your kids and it's, that was horrible, you know, I felt like I had to explain myself and I didn't do that, I just thought, no, why should I have to explain myself, they don't know how it feels in my head, they don't know how I feel"

Ann

"it was like, I couldn't do it so I had to find a way for them to be well looked after, because I, I felt like I wasn't capable, I wasn't doing a good job and I was (pause), just I, I felt like I couldn't do it. (pause) And I suppose that was thinking of them instead of having them there with me and seeing me like that all of the time, that wouldn't have been good for them either"

Ann

Liz and Mary also spoke about forcing themselves to get their children involved in activities so they would get a break and not miss out.

> *"I always kind of, really focused to make sure they didn't miss out on anything, like I mean, I brought them to parties when I really couldn't even string a sentence together"*
>
> Mary

> *"I put my daughter into playschool early, just for her as well she needed a break from her brother, and also to force me to go out of the house"*
>
> Liz

Within the sample of mothers interviewed, the ability to 'pretend' or hide their depression and make attempts to protect their children varied. For some, it was inconsistent while for others the severity of their depression meant it was impossible.

For Liz, the severity of her depression impacted on her ability to be emotionally available to her children. Basic physical needs were met but no emotional bond or attunement was experienced.

> *"He was put in eh, in his cot which, and left to his own devices. Because I had to deal with the other two as it was…and he just was there, he woke, he cried, he fed, that was it. And then he fell asleep, you know we changed him there was no, em I know I breastfed, I know I breastfed with him, but going through the motions"*
>
> Emma

Two of the women, whose children are now in middle childhood, identified that their children had emotional regulation difficulties, which they link to their PPD.

"I was very inconsistent… and my son, last year was diagnosed with ADHD…ADHD symptoms are very sim-, they're identical to someone not being able to self-regulate…So I actually think the attachment suffered."

Paula

"whether it's the remains of what happened 8 years ago, that's one thing that it'll always play on my in my head…[he is] fighting over everything, fighting with everybody, fighting, you look at him and he's fighting and lashing out, physically lashing out, lashing out with anybody and everybody… he will be the one that I will look out for more so in you know in, when they come to teenagers and you know and I always try and talk to him"

Emma

In the excerpt below, Paula talks about how she believes repair is possible. Although the marks may remain, as she indicated earlier when speaking about her eldest son and what she believes are his attachment difficulties, the relationships can be rebuilt and she can be the secure, stable mother her children need.

"when you get back on track after that you feel you can manage and you feel your unstoppable then…and your children really, really see that. Your children see everything you can be then. Once you get back on track."

Paula

Although most women were aware of the potential for their PPD to be detrimental to their children, and expressed concerns about this, overall the majority of women interviewed were reassured by the fact that their children are happy and healthy now, and reported feeling a

strong bond. Therefore, they did not appear to hold the view that their PPD had any long term impact on their child's development or attachment.

It is possible that severity and timing of their PPD had an impact on this. In addition, six out of eight of the women interviewed lived with their partner or husband during their depressive episode. Therefore, their children had another primary attachment figure during this time. It was clear from listening to the women discuss this topic, that their understanding and definition of bonding and attachment varied, highlighting the arbitrary nature of these labels used within society.

4.5 Superordinate Theme 3: Journey to Recovery

This superordinate theme refers to the process of overcoming PPD, as experienced by the eight women interviewed. This theme encapsulates how the current dominant medical approach to treatment of PPD, left many women feeling disempowered, further traumatised and stigmatised. Many women were failed by the system, which fed into the self-blame cycle and reinforced the idea that the problem lay entirely within the mother. The healthcare system did not promote mother-infant attachment. Rather, it focused entirely on the physical needs of the baby, ignoring maternal and infant mental health. The women recovered their lost voice and sense of self through connecting with other women in group work and 1-1 counselling. The acceptance and normalisation in this relational work helped them to accept themselves and forgive themselves for not being perfect. Regret and loss of their precious time with their babies was unfortunately a residual experience for most.

4.5.1 Problem located within the mother

Difficulty in disclosing their depression was identified by many women. The stigma associated with feeling depressed after having a baby, led them to pretend everything was ok.

> *"Anybody that I've spoken to that has had postnatal depression, none of them told anyone…and why, because it's not the norm…you're supposed to be able to get up, get on with it you know, cause everybody else does"*
>
> Emma

> *"it's the guilt really because you've had a baby you should be delighted, and you are, but you feel awful then because you have this perfectly healthy adorable gorgeous child and then you have all these situations going on in your head…it's so hard to admit about postnatal depression because it's like your nearly being ungrateful."*
>
> Mary

> *"You don't tell professionals anything…You're terrified of public health nurses, your absolutely terrified. Pretend everything's grand have your bloody house spotless"*
>
> Paula

Some of the women, like Paula, identified a fear and distrust of professionals. They felt terrified that their baby would be taken away if they disclosed how they felt.

> *"and I think a lot of the fear is that they will take the baby off you I think that's a huge fear…that they would come and kind of agree with your irrational side of your brain that you aren't the right mother and say it to you, no you're not and come and take the*

baby you know…it's like this half relief and then your like no no no he's mine, don't take him

Liz

A number of women described the lengths to which they went to keep up appearances, in order to create an illusion of being ok and look as though they were coping. Liz, below, describes how she used to ensure her daughter's clothes were perfectly matched when she sent her off to playschool in the mornings.

"if you send them off right, people don't notice what's really going on at home, what's really going on in your head when you're standing there… people won't notice that actually mammy's gone mad in the head (laughs)."

Liz

Threats of admission to psychiatric hospital for two of the women prompted them to pretend to be ok.

"she [GP] wanted me to go to [Psychiatric hospital] and that was a big, Jesus I'm not that bad I'm grand, I'll be fine you know and then of course you're pretending again, you're pulling up the socks."

Emma

For Emma, who had hidden her PDD from her family and friends, the stigma of admission to hospital was too strong.

"what if I never came out, that's that was always the thing, em what would happen to everybody. I didn't want anybody coming to visit me like that, didn't want anybody knowing, never mind the fact that you know I was dealing with this myself and obviously

the other half but you know, I hadn't told, I hadn't told my parents, I hadn't told (husband) parents, I hadn't told anybody"

Emma

For many of the mothers interviewed, the diagnosis of postpartum depression did not initially provide any relief and was not experienced as helpful. The diagnosis in seven out of eight cases was made by a GP, and medication was the first treatment option offered. All seven participants indicated a pre-existing negative view of anti-depressant medication and a reluctance to take the medication. Two participants refused, the other six took the medication, with some finding it helpful, and some not.

"She [GP] prescribed antidepressants which I wouldn't take…Because I just felt it went against everything I do… Em and I've heard so many people caught into them…And eventually I had to start taking them. Very ashamed, extremely ashamed about having to do it and also they weren't helping"

Niamh

In most cases, the diagnosis of PPD was provided with no consideration of the context in which the depression was occurring, such as previous trauma, lack of support, unrealistic expectations, low self-esteem, exhaustion and unrealistic demands. The diagnosis of PPD in many cases, located the problem firmly within the mother, reinforcing the self-blame, guilt and shame already felt by these women.

"the public health nurse was not at all helpful, made me feel like I was a massive problem."

Paula

"my partner basically, he said to me, I feel like there's something wrong with you, maybe go see a doctor…I went to see my doctor and they diagnosed me with postnatal depression…it was very hard for me to take that on, take that on board because I didn't fully understand exactly postnatal depression...So I went home and I kinda down-spiralled with my postnatal depression, I, I felt very, I felt very suicidal."

Ann

In this excerpt, Ann describes her experience of receiving a diagnosis of PPD, six weeks after giving birth to twins. She could not identify with the label, yet, like all of the women interviewed she took the diagnosis and all of the guilt and self-blame that goes with it. The problem was located within the mother with no consideration of the environment or wider context. As was the case for all of the participants, no emotional support was offered in the early stages. Ann goes on to describe her own experience of the 'downward spiral' and subsequent admission to psychiatric hospital, which was very disempowering.

"So things got really bad and they ended up sending me to hospital… And I was there I'd say for about 2 months…they put me on medication…they done some therapy with me as well"

Ann

Although she identified positive elements of her treatment in hospital, the separation from her twins was traumatic and disrupted their attachment relationship. Hospital was a safe haven, a break from reality, however the separation was de-skilling and it reinforced feelings of inadequacy, providing the message that she needed to be 'fixed' by experts. On release from hospital, she returned home, without the ongoing support that she needed more than ever, and unsurprisingly the depression returned. She did not seek help at this stage for fear she would

be sent back to hospital, instead, she described how she battled her depression alone for two years.

Niamh also recounts an experience of treatment in psychiatric hospital which was very disempowering. Traumatised and feeling suicidal and very depressed, she reluctantly went into hospital and was prescribed antipsychotic medication. As a psychotherapist with an understanding of mental health difficulties, she realised that her psychiatrist suspected bipolar disorder and felt this did not fit with her premorbid presentation. She describes feeling like she wasn't being listening to and a power struggle developed between her and her treating psychiatrist.

> *"he was concerned about that [bipolar], it was just a shame he hadn't thought to say that to me, because where my head was, I'm not being believed."*
>
> Niamh

She went to great lengths to disprove, as such, his formulation, including requesting that he speak to her sister for collateral. Illustrating how her sense of self, her voice and her power was becoming eroded, even at this stage she stated the following;

> *"I strenuously rejected it and said that I would leave.. Em and I think part of that was.. please don't tell me there is something wrong with me as such… This feels temporary. It feels like it wasn't there before hand. And now you're going to do what I was most afraid of, which is I'm going to get into the psychiatric services, I'm going to be drugged up to the eyeballs, how the hell will I ever get back. And there was enough of me there to do that"*
>
> Niamh

On another occasion, when questioning her medication, she received a stern response from her psychiatrist.

(raised cross voice) "me doctor you patient"

Niamh

However, she noted that it was the kindness and humanity shown by him on other occasions which was most meaningful to her.

"seeing that human face was very important, (tearful) very very important"

Niamh

Niamh experienced some hurtful comments from a number of members of nursing staff which contributed to her feelings of not being listened to or believed. In a very powerless, vulnerable position, her ability to see these comments for what they were indicated a huge strength of character.

" 'don't worry not everybody was born to be a natural mother'..'How long are you going to be here, why would you not get back to your husband, he's doing all the work'.. 'I don't think there's a thing wrong with you, eh either that or your very good at hiding it'...I took it as, again, not being believed…I just needed to be believed"

Niamh

In contrast, Chloe reported feeling relieved when she was diagnosed with PPD

"it was only after I actually told, like actually went and spoke to the doctor and said what was wrong with me, I actually started feeling that little bit better"

Chloe

Chloe, who had two previous miscarriages before she gave birth to her son and subsequently developed PPD, was offered anti-depressant medication which she declined. Instead she began writing about her feelings and experiences, started exercising and trying to get more breaks. Her diagnosis prompted her to make changes which lifted her mood, such as gaining clarity in her thinking from writing and gaining mastery and pleasure from her jogging and planning activities. However, for Chloe, who indicated core difficulties with low self-esteem, as discussed earlier, the diagnosis did not ultimately alleviate her self-blame and guilt. She indicated that she was planning to begin one-to-one counselling to help with some of these difficulties.

> *"I had post-natal depression, I still felt like I was just failing, that like the reason I had it was because I was failing because I couldn't handle what I was doing and I probably still think that sometimes that it's just that's why I had it was because I couldn't do it."*
>
> Chloe

4.5.2 Lack of Containment

In many ways the system failed these women. As identified earlier, they felt enormous amounts of fear and inadequacy. These feelings were not contained by their environment and so they continued to deteriorate, further into the downward spiral. The help that was on offer in the early days of their PPD was not attuned to their distress.

> *"It got to break down stage, before anybody helped actually. And that's, that's not right. That's really really really not right."*
>
> Niamh

I'd said I had a broken leg, I would have got more offers of help than I did say I had postnatal depression… People just didn't want to know

Liz

All eight women identified a lack of psychological support, which each believed would have been beneficial in the early stages. In addition, empathy, kindness and continuity of care was identified as important. Participants felt that having someone with knowledge of PPD, who could reassure, normalise and provide hope, would have benefitted them greatly. Many of the women indicated they were unsure how receptive they would have been to interventions in the early stages, however as was noted by Liz, *"it would have been nice to be asked, you know, how is mam doing".* Also, as noted by Paula, culture and society have a role to play in lowering barriers to seeking and accepting help, *"if I lived in a society where I knew the likelihood of me getting depression was high, that it was ok, that these are the supports in place."*

Participants described receiving the diagnosis of PDD from their GP along with a prescription for antidepressants and continuing to live in misery while trying to care for their children.

"Once I got the diagnosis initially, I was like, instead of doing anything about it. I kind of just carried on… when I think about it now, makes no sense. Cause, you know if they told you you had, I don't know, cancer or a broken leg, straight away you'd go get treatment or whatever"

Mary

"I'm going to put you on some tablets, you have postnatal depression and of course that was it, just put you on tablets you have postnatal depression, deal with it…just pawning me off with pills probably wasn't the greatest thing to do."

Emma

Margaret describes how during her PPD her boyfriend was trying to be supportive but could not attune to what she needed. In the example below, Margaret, who was filled with fear and feelings of inadequacy, predisposed by trauma and her own attachment history of abandonment, needed to feel contained in order to meet her baby's attachment needs. By being unable to talk openly about how she felt, she was further stifled and supressed. Luckily for her, counselling was suggested by her public health nurse and encouraged by her boyfriend, who recognised that he could not meet her emotional needs. In this therapeutic relationship, she achieved the containment she needed and began to heal some of her core beliefs of inadequacy.

> *"(boyfriend), he's such a great guy but he doesn't know how to handle the feelings and talking and like even if we have an argument and he'd rather like sweep things underneath the carpet than actually resolve things and stuff like that so he, it's very hard, he wants to be supportive but he doesn't know how"*
>
> Margaret

Many of the women interviewed indicated how their relationships changed as a result of their PPD. For some, this was a positive thing; they were better able to ask for help, more open in their communication, and more able to say 'no' to taking on too much. For others, they felt dismissed and let down by family members or friends. Similar to their treatment by the health service, their voices were silenced and their emotions were supressed.

> *"my mam was saying…I'll be there for you like you know, mind the babies and do everything like that. She didn't know how to deal with my emotions… And that was a little bit kind of lonely as well in the sense of, I wanted to sit and talk to someone… I suppose looking back now that was a big big thing, talking about it is really really important… and just having that bit of space where you can speak to someone… whether its outside or in your family, really, really important… And I think that's why*

it took me so long to recover, because I wasn't, I didn't have, (pause) I wasn't I suppose doing the right things, and I didn't have the right supports and that's what really prolonged it"

"I think people are probably afraid, like my family, are probably afraid to talk about it with me"

Ann

"I brought one of my sisters who I thought was close em and (pause) she turned around and told me, sure it'll be fine, I went to see counselling and I've pulled up my socks that's all you need to do is pull up your socks. And that was eh a slap in the face I have to say now without a doubt, a slap in the face and because she was one of the first that I told"

Emma

Emma described being very hurt by the response given above by her sister. This response was contrasted with her mother-in-law, whose immediate response was to offer help. This simple powerful gesture, conveyed acceptance, support and lack of judgement to Emma.

"the first thing she said is, what can I do to help, as in completely different spectrums of the situation… and that to me was an awful lot more, means an awful lot now and even then meant an awful lot more than, pull up your socks you'll be grand"

Emma

Liz and Paula both noted that their experience of PPD has altered their relationships with certain family members and friends.

"*I still hold some sort of grudge against my brother, who walked past my front door every day and never came in…I haven't been able to get over that"*

Paula

"I'm more wary of people now as well, em after telling some people and them hearing me on the radio and their reaction towards me and, em I think it's made me more of a guarded person."

Liz

4.5.3 Recovery through connection and acceptance

Many of the women attended a group for women with postpartum depression, which they found invaluable. The shared experience of being a mother who is going through postpartum depression and being able to openly discuss how they were feeling, without being judged, was crucial to many. Having their feelings normalised, and feeling accepted by the group, assisted the women in accepting themselves, and forgiving themselves for not being perfect.

"the group counselling…it saved my life in a way that it gave me a life back, do you know, I mean what I had, what I was living for those whatever, 18 months, it wasn't a life…there was no judgement or there was no nothing and I think that was why it worked for me"

Mary

"it was the best thing I ever did…because it was great to talk to other women who had been through the same thing and there was no judging, you could say what you felt."

Liz

Similarly, one-to-one counselling was also identified as an intervention which aided recovery for six out of eight of the women interviewed.

> *"going to see her (counsellor) was a saving grace, without a doubt, to the extent that I probably wouldn't be here without her you know that sort of way, we did build up…a rapport."*
>
> Emma

However, two of the women had negative initial experiences of one-to-one counselling. Mary attended two different counsellors whom she felt she did not click with, before attending a group and then a third one-to-one counsellor whom she found very helpful and still sees occasionally for support. Niamh had quite a negative experience with the first counsellor she attended before her admission to psychiatric hospital. She described how this counsellor was very directive in her approach and could not attune to her needs and contain her distress.

> *"it was a horrendous experience, just horrendous…I was actively suicidal at that point. And I suppose what happened was any bit of hope was taken away. Em because the final piece was, well there's no point in scheduling another appointment because you're not going to do what I ask you to do anyway, and at that point a door closed and I thought I am unhelpable"*
>
> Niamh

This experience fed into Niamh's beliefs that the she was to blame, that she was flawed and that her situation was hopeless. She was subsequently admitted to psychiatric hospital where she availed of one-to-one counselling from a family therapist, which she found very helpful.

> *"She was excellent. She was really good. Between a balance of being practical and being very empathic, she was really, really good and very straight and very much let's*

get at this anxiety, let's look at this controlling nature that's going, all of this she was really really good. Really really good."

Niamh

In this description, Niamh conveys a sense of collaborative work within the therapeutic relationship, which was a shift from the directive 'expert-led' approach she had been provided with prior to this.

Mary discussed how she found the experience of the therapeutic process to be a challenge in itself, alluding to the earlier theme of core issues emerging. Similar to Niamh's experience, perhaps Mary did not feel safe and contained enough in her early experience of one-to-one counselling to begin this core work.

"I do think that you have to be mentally and emotionally ready to deal with everything, because I mean it throws a lot, you know from private feelings that you never would discuss with anybody to you know your insecurities and your doubts and your guilt, it throws a lot of stuff at you…you start nearly pulling at threads and you don't know what's gona come out, do you know what I mean. You don't know what's gonna be unravelled there. You pull at one thread you don't know how its gonna effect your whole being if you like…it's kind of a contradiction because you're at a point where you feel that you just, you can't do anything so your very very very vulnerable, but yet you have to be the strongest that you've been for a long time. Do you know that way so you, it's a complete contradiction."

Mary

Through this therapeutic work, many of the women reported ways in which their thinking styles have changed and they have more self-compassion and regained some, but not all of their confidence.

> *"it was very hard to get here, it took a lot a lot a lot of work em and not to sound like I think I'm fabulous, but I do think I'm pretty fabulous to have gotten to the point where…Because it's a complete mindshift"*
>
> Mary

> *"I'd say probably even a year after the group, em your confidence kinda starts coming back, I don't think I'll be the same person again that I was, em, I think my confidence will come back but it won't come back fully"*
>
> Liz

In addition, many mothers identified that their own self-care and allowing themselves a little bit of time for themselves was important to maintaining good health. Although it was evident that this is difficult to do and often associated with inner conflict and guilt.

> *"understanding that you're separate was huge for me. You are not just a mother. You have your own needs, and if your needs are not met it's really, really difficult to keep giving."*
>
> Paula

Building up a support network, feeling accepted and part of something was also an important part of recovery. Through making connections with other women, they were no longer isolated, and experienced vitality in sharing their experiences, positive and negative, of being a mother.

All eight women interviewed attempted to make sense of their experience and why they had PDD. Many linked it to pre-morbid traits, such as anxiousness or perfectionism. Others linked it to their life experiences of abandonment by parents, grief or trauma. Only one mother suggested hormonal imbalance, related to her IVF treatment, as a contributing factor, in addition to other, more prominent factors.

Ann, like many of the women interviewed, makes sense of her experience and finds a way to reframe her diagnosis, in a way which alleviates some of the guilt and self-blame. The use of the medical model and terminology can be useful to reduce self-blame and stigma and evoke self-compassion. She tries to forgive herself for how she felt, rationalises it, and blames it on the illness. However, this sentiment is portrayed somewhat like an affirmation, without a sense of true belief behind it.

> *"And you know sometimes I say to myself, ok this was an illness you know and it's normal to feel like that and try not to beat myself up too much about it but mothers guilt and all that as well…I've had to stop and kind of be, ok I was ill, and you know I can't keep beating myself up about it"*
>
> Ann

Ann, like all of the women interviewed, is conditioned to take all of the blame. Guilt is viewed as a normal, universal experience of motherhood.

> *"you always have a certain amount of guilt no matter what way you do it…once you're a mammy you have the guilt so that's just, you kind of have to just take it on the chin"*
>
> Mary

While all of the women interviewed expressed a view that their PPD was "nightmarish", "horrific" and said that they wouldn't wish it on anybody, some found meaning from their experience, and felt they grew and developed from it.

"I do wonder whether I got postnatal depression after (second child) so I could cope with you know what was coming with (third child)…it definitely made me stronger"

Mary

"I'm as happy now, you know really really happy now and yeah, that's when decided then to go to college to educate myself. My whole life I suppose turned around, you know… now I kinda I want to focus on maternal mental health myself now in any way I can"

Ann

Like Ann, all of the women interviewed expressed a desire to help other women who were experiencing PPD. This was conveyed through actions such as, taking part in this research, talking about their experience on the radio, fund-raising, starting counselling courses, volunteering for charities for women, or lobbying and advocating for improvement in women's mental health services. All of the women voiced the hope that the supports, services and our culture for maternal mental health would improve for other women, and particularly for their own children in the future.

"working with the other mums it has allowed me give something back…And that's been terribly important"

Niamh

"*I went on the radio… to help women out there, you know trying to get the awareness, you know get people talking about it"*

Liz

"I didn't want (second child) to ever think that I didn't want her, do you know that way, and I mean it's like I suppose it's something I'll have to explain to her when she's older. Because again I would want, if she was to ever have kids I would want her … to be aware and I suppose I wish maybe that someone had been aware for me

Mary

4.5.4 Regret and Loss

As is commonly seen in depression, many women reported a loss of memory for some of the most difficult parts of their postnatal depression. This loss of memory was experienced, in some cases as a grief, due to the additional loss of memories of the early weeks and months with their babies, a time considered precious by many women. The mental block described by some of the participants can also be interpreted as a protective strategy, blocking out the painful memories, particularly in relation to caring for their children. Indeed, within the interview, many women were observed to protect themselves from painful memories by dipping in and out of their recall of difficult times, pulling themselves back from painful memories through humour, changing the subject, or moving from a specific memory to a general statement. Thus there is a to and fro and light and darkness within the interviews.

"my head was so far removed, I was removed, there was no, I don't remember kind of looking after anybody, I don't remember, I don't know whether it's you know, the mental block has gone up and, and just for fear of bringing it back down"

Emma

"I have no recollection of any of them, right up to, probably right up to the youngest fella starting school…so that's the best part of 10 years nearly gone"

Emma

"…it was open the press and see what's in it and if there's nothing in it yis are going to school with crackers, you know that sort of way, and I didn't care…em so so all of them kind of you know all of them feelings click in and yeah it's a bit kind of nightmareish when you think about it (pause)…but they're still alive and I didn't kill them, (laughs) as in food wise, I didn't poison them"

Emma

In this excerpt, Emma describes how in the lowest ebb of her depression, she lost the ability to care for herself and for her children, and gives an example of providing inadequate school lunches for them. Emma recalls this memory then moves away from it, indicating how a flood of painful feelings return when she dwells on it. This highlights how as researchers we are privy to only snippets of insight into the inner world and experience of participants but yet we can learn so much from these pockets of insight. It also highlights the importance of open, sensitive, interviewing, allowing the participant to let the researcher close to a memory, but pull back when it becomes too much. In this example, the participant is protecting herself.

"I feel like I can't remember them, I didn't get to enjoy them…because of the way I was feeling. And that's sad, you know, and I do be saying sometimes, god such a waste. Two years a waste and sometimes I'd just love to go back and not to feel like that again, and just spend those two years being happy with them"

Ann

"half the time I don't even really remember…I've seen photographs of myself at the time and I'd be, I'd have been done up, my hair would be done, my make up would be done all that sort of thing, but I'd looked.. like I wasn't there.. I looked sad if you know what I mean"

Mary

Although these women have largely recovered from their depression, the pain and regret from their experience remains.

"As well as I am now today, I don't think I'll ever be able to talk about it without crying and getting upset"

Ann

4.6 Reflections on writing up the analysis

The dynamic of the hermeneutic cycle continued in the write up of the results section. Unexpectedly, the write up felt very much like a continuation of the analysis of the data. The separation of the themes into superordinate categories felt forced at times due to the strong connection and overlap between them. For this reason, writing up of the results was a lengthy process and I returned to the original transcript and exploratory codes many times in the write up to retain a sense of what distinguished the themes from each other, while also trying to ensure that the narrative did not become fragmented and the links between the themes were not lost. I found myself writing the themes out again in a diagram with links and arrows on a number of occasions to ensure that certain emerging themes should not be in different super-ordinate categories.

CHAPTER 5: DISCUSSION

5.1 Chapter Introduction

This chapter provides a review of the aims of the current research, followed by a detailed discussion of the findings, with reference to the relevant literature. Limitations and strengths of the study are considered and the implications of the findings in terms of clinical practice and future research are discussed. Finally, the researcher's reflections and comments on the project are provided.

5.2 Review of the Research Questions

The aim of the current study was to qualitatively explore the experience of postpartum depression and the mother-infant relationship, with women who have recovered from PPD. The following specific research questions were explored:

- How do women who have recovered from PPD make sense of their experience of PPD?
- How did their PPD impact on their relationship with their baby?
- What helped these women to get through this difficult time? And what else (if anything) would have helped?

The data from interviews with eight women who have recovered from postpartum depression was analysed using interpretative phenomenological analysis, revealing three super-ordinate themes; 'Feeling Inadequate', 'Fear-Filled Caregiver' and 'Journey to Recovery'.

5.3 Findings in the context of the previous literature

In order to facilitate clarity, the main findings of the current study will be discussed in the context of the previous literature under the three superordinate theme headings. All three superordinate themes address the first research question, providing an insight into the experience of postpartum depression from the prospective of women who have recovered. The second superordinate theme, 'fear-filled caregiver' addresses the second research question, which sought to understand how women who have recovered from PPD experienced their relationship with their baby during their depression and how their depression may have impacted on the relationship. Finally, the third superordinate theme, 'journey to recovery', addresses the third research question; what helped these women overcome their depression and what else do they perceive, would have been helpful.

5.3.1 Superordinate Theme 1: Feeling Inadequate

Fourteen years ago, Cheryl Beck (2002) completed a metasynthesis of 18 qualitative studies of women's experience of postpartum depression. Beck found that incongruity between women's expectations and the reality of motherhood was a dominant theme across all of the papers she reviewed. As outlined in the literature review, this disparity between the dream and reality of motherhood continues to pervade the qualitative literature (Barr, 2008; Hall, 2006; Knudson-Martin & Silverstein, 2009; Mollard, 2014). The findings from the present study were consistent with this theme. Many women portrayed an idealised vision of motherhood and subsequently set unrealistic standards for themselves as mothers. When they felt they were not living up to these standards, the women then perceived themselves to be inadequate, failing, and 'bad mothers'. Similar to previous findings (Mauthner, 1998; Mollard, 2014), many women felt guilty and ungrateful for feeling sad and believed they were depressed because they

were bad mothers. As noted by Patel et al. (2013), rather than alleviate feelings of guilt, for some women, the diagnosis of PPD confirmed their belief that they were inadequate.

These feelings of inadequacy developed into what that women described as, "the downwards spiral" of postpartum depression. This downward spiral has been referred to consistently throughout the qualitative literature, (Beck, 2002; Mollard, 2014). The women interviewed reflected on how they felt angry, overwhelmed, sad and lonely during their depression. Many were suicidal and experienced self-hatred. It is interesting that this downward spiral appears to be a universal experience of PPD. The progressive element of the downward spiral, highlights the importance of early intervention, it also raises queries as to how PPD is frequently undetected and untreated, (Dennis & Chung-Lee, 2006). Many of the women experienced extreme guilt and shame for their perceived inadequacies and therefore found it difficult to disclose their feelings. Similar to findings from previous studies (Hall, 2006; Knudson-Martin & Silverstein, 2009), many of the women interviewed hid their depression from family, friends and professionals. Perhaps these attempts to hide the depression prevent professionals from recognising the downward spiral. It is important to look at the wider societal and cultural context of PPD and the reasons behind the consistent finding that women feel unable to speak about dysphoric feelings following childbirth due to guilt and shame.

Through the use of IPA methodology, the current study added an interpretative level to these findings. For many of the women interviewed, their environment reinforced and maintained these unrealistic standards of motherhood. Similar to findings from previous qualitative studies (Beck, 2002; Mollard, 2014), participants believed they were inadequate in comparison to other women, both within their family and friends and within the general public. These feelings were accompanied by extreme shame for not being 'good enough'. Negative experiences in motherhood were not easily voiced by the women in the current or previous studies, (Knudson-Martin & Silverstein, 2009). As noted in the results section, many women felt that their friends

and family were not open about their own struggles with motherhood, suggesting that openness about negative experiences of motherhood is not encouraged by society.

The healthcare system also reinforced this unrealistic expectation of motherhood by focusing entirely on the physical needs of the babies, while overlooking maternal and infant mental health. One participant provided an example of how she felt pressurised to continue expressing breastmilk for her babies despite her exhaustion, declining mental health and desire to discontinue. In this example, this mother was treated in a very mechanical way, as provider of milk with no acknowledgement of her voice or her ownership of her body and her babies. In other examples, many women indicated that check-ups with healthcare professionals focused on their physical health and healing after childbirth. For others, enquiries by healthcare professionals regarding their mental health and coping were made early in the postpartum period, prior to the onset of their symptoms, at which point they felt fine. As PPD symptoms seldom emerge during the immediate postpartum period, this is not an ideal time for screening, (Pawar et al., 2011). Some of the women felt judged and indicated fear and distrust of GPs and public health nurses. Fear that their baby would be taken away from them was identified by a number of women interviewed.

Even though they were no longer depressed, many of the women interviewed still regularly experienced feelings of guilt related to their parenting. Similar to findings from previous studies (Barkin & Wisner, 2013), guilt was viewed and accepted as a universal element of motherhood. Many of the mothers viewed their role as self-sacrificing. Some struggled with the conflict between expecting to be able to give relentlessly to their children when their own needs and desires were not being met.

Held and Rutherford (2012) examined the portrayal of postpartum distress in popular magazine articles and advice books over the past 50 years. The authors proposed that persistent reluctance

to situate motherhood itself as the cause of serious emotional distress and a consistent focus on changing mothers to adapt to their role rather than changing the parameters of the role itself, has led to the rarely challenged assumption that motherhood and distress should not mix.

In their qualitative study of PPD, Buultjens and Liamputtong (2007) highlight how motherhood is idealised while simultaneously trivialised and undervalued within society. Homewood et al. (2009) refer in their qualitative study to the powerful association between breastfeeding and "good" mothering. Yet, in western society many women are shamed for breastfeeding in public, further highlighting the authors proposed, how mothers can be marginalised in a patriarchal society, (Grant, 2016).

Indeed, it could be argued that the scientific and academic community have a role to play in maintaining this discourse on motherhood. From John B. Watson's claims that a mother's love and affection is "a dangerous instrument" (1928, p.87) to Leo Kanner's (1968) link between "refrigerator mothers" and autism, the scientific community have a history of contributing to the discourse on the "good mother" (Held & Rutherford, 2012). Bowlby's attachment theory places value on the natural, innate ability held by mothers to provide a safe base for their infant and to regulate their needs. However, the implied consequences of maternal inadequacies in this capacity is enormous. Furthermore, Bowlby's claim that even short infant-maternal separations can contribute to infant attachment difficulties, has been seen as oppressive towards women (Held & Rutherford, 2012). In response to the persistent issue of 'mother-blaming' in infant metal health, Zeanah and Larrieu (2000) point out that blame should not be considered part of the scientific investigative process and insist that researchers should never hesitate in reporting their findings for fear of being perceived as mother-blaming. Furthermore, pertinent to the literature outlined in this paper on the interaction between PPD and mother-infant attachment, the authors highlight the influence of cultural belief systems in shaping parenting practices and the large variability in how risk factors express their influence. Zeanah and

Larrieu state, *"Our best scientific methods deal only with probabilities and not with absolutes. In a relational model, causality never is simple, linear, nor unidirectional. And, if we are honest, we will acknowledge that in clinical work as in research, the largest amount of the variance in outcomes usually is unexplained. The humility inherent in this fact alone should be a sufficient antidote for the urge to blame."* (2000, p. 444). The authors conceptualise blame as a form of countertransference and emphasise the importance of reflection. Although this is in relation to clinical practice, there is relevance for researchers here also. Infant mental health can be an emotive topic. It is important to reflect on biases and assumptions and to consider the contextual factors and the wider societal influence on the mother-infant relationship. As is evident from the current and previous research, viewing the mother-infant relationship within a vacuum which does not exist, maintains the ideology of the "good mother" who is solely responsible for all infant outcomes. This discourse, as we have seen from the current and previous studies, contributes to maintaining the stigma associated with postpartum depression.

As noted by Choi et al. (2005), the patriarchal ideology has been challenged by feminist writing for many years. However as evident from the current study and previous literature presented here, the ideology of the "perfect mother" still exists and continues to have a detrimental impact on women who are vulnerable to PPD.

5.3.2 Fear-Filled Caregiver

As discussed in the literature review, anxiety has been identified as a core feature of postpartum depression (Beck, 1992; Hendrick et al., 2000). However, the impact of this anxiety on the mother-infant relationship has not been explored in great detail within the qualitative literature. Within the current study, fear emerged as a prominent theme. The women interviewed stated that they experienced feelings of terror during their PPD. For some, this fear manifested as

anger, feeling numb, feeling trapped or seeking to escape their situation by any means, which is comparable to the flight, fight, freeze reaction to fear highlighted in the literature review, (Guedeney, 2011; McCluskey, 2011). For some of the mothers, this fear may have been associated with previous trauma or stress such as traumatic births, miscarriages, caring for very premature babies, failed IVF attempts or stress related to difficulties conceiving. While for other women, their fear appeared to be linked to feelings of inadequacy and feeling as though they were not good enough for their children. Some of the women indicated that becoming a mother tended to expose old wounds, such as a history of abandonment or insecurities. The idea that giving birth activates core vulnerabilities, points to the quantitative findings highlighted in the literature review relating to risk factors for PPD. Insecure maternal attachment styles and low self-esteem have been identified as risk factors for PPD, (Martini et al., 2015; Robakis et al. 2016). Maternal attachment style was not assessed within the current study. However, as indicated in the results, many participants reflected upon experiences and feelings, which may indicate that their attachment system was activated during their experience of PPD.

As noted by Guedeney et al. (2011), the attachment system, which is operative throughout the lifespan, becomes powerfully activated during and after any experience of fear, physical or psychological pain or uncertainty, such as following childbirth. McCluskey (2011) distinguishes between the caregiving and care-seeking systems in the dynamic 'goal-corrected empathetic attunement' (GCEA) process outlined earlier. McCluskey highlights that *"when fear is aroused, empathy vanishes, permanently or temporarily, and the capacity for exploration goes on hold*" (2011, p.15). In other words, if a mother's own attachment needs, or needs as a care-seeker are not met, it will impact on her capacity in her caregiving role. As identified in the literature, a vital role of a mother as an attachment figure, is to regulate her infant's fear and distress, Bowlby (1979). However, when the mother is in a state of fear or

distress herself, her capacity to fulfil this role is diminished (Guedeney, 2011; McCluskey, 2011).

Within the current study, many of the mothers experienced difficulties attuning to their baby's needs due to their fear, self-doubt and depression. The women provided examples of over-reliance on routine rather than reading their babies cues in order to minimise their anxiety. Other examples included difficulties with bonding which may be linked to fear. For some of the women who had previous miscarriages, it may have felt unsafe to bond, this finding however has not been supported within the literature (Bicking, Baptiste-Roberts, Zhu, & Kjerulff, 2013). Within the interviews, some of the women used the term attachment to describe feelings of closeness and an emotional connection with their baby, a term synonymous with bonding (Bicking & Hupcey, 2013). Some of the mothers reported feeling distress and guilt during their PPD, as they did not experience a strong bond with their baby immediately, which they believed they 'should' feel. This further highlights the impact of expectations on women's experience of motherhood and on postpartum mood. PPD has been associated with impairments in bonding (Moehler, Brunner, Wiebel, Reck, & Resch, 2006), with some researchers querying whether bonding impairments may contribute to PPD (Moehler et al., 2006). However, the concept of bonding has been criticised for placing unnecessary anxiety and guilt on mothers, (Crouch, 2002). The concept was popularized in the 1970s by Klaus and Kennell (1976), and contributed to significant changes in perinatal care such as 'rooming in' and 'kangaroo care', (World Health Organisation/UNICEF, 2009). However, the literal interpretation of the concept and the suggestion of a 'sensitive period' for bonding has drawn criticism and caused Klaus and Kennell to clarify their position; *"Humans are highly adaptable, and there are many fail-safe routes to attachment. Sadly, some parents who missed the bonding experience have felt that all was lost for their future relationship. This was (and is) completely incorrect".* (1982, p.55-56). (Klaus, Kennell, & Ballard, 1982) (Klaus, Kennell,

& Ballard, 1982) Some of the women who participated in the current study, reported feeling a strong bond with their babies. Others, however, reported that although they knew they loved their children, they did not feel a strong bond during their PPD. Unfortunately, these feelings were accompanied by severe guilt and shame.

Similar to Beck's (1996) findings, many of the women who participated in the current research discussed ways that they attempted to protect their children from their depression. Fully aware of the potentially detrimental impact of their mood on their child's emotional development, some of the women pretended or put on a brave face in front of their children, thus attempting to be congruent to their infant's emotional state, rather than their own emotional state (Fonagy & Target, 2005; Winniott, 1989). Others, ensured that their children had a break, by getting them out to preschool, crèche or other activities. However, the extent to which the mothers were able to implement these protective measures and to implement them consistently, seemed to depend on the severity and duration of their depression. Most of the women interviewed expressed concerns about the impact of their PPD on their children. Two of the women felt that their children experienced lasting difficulties with emotional regulation as a result of their PPD, while the other six women indicated that their children were currently happy and healthy. This represents the opinions expressed by the mothers who participated in the current study of retrospective PPD which involved no formal measure of child outcome. It is likely that similar to the findings outlined in the literature review (Lefkovics et al., 2014; Wan & Green, 2009), severity of depression, chronicity, maternal behaviour, availability of alternative attachment figures and level of social support mediate the impact of depression on child outcomes.

5.3.3 Journey to Recovery

What was very striking about the narratives of the women in the current study, was the lack of containment of their distress. These eight women experienced high levels of fear, vulnerability and perceived themselves to be utterly inadequate. Similar to findings in previous qualitative research (Beck, 2002; Knudson-Martin & Silverstein, 2009), they felt silenced by their environment and ashamed of their feelings and so, tried to cope without asking for help. Some women asked for help, but the help they received did not attune to their distress nor did it contain their anxiety and depression. For many of the women interviewed, their fear and feelings of distress were uncontained by their environment, and they continued to experience the downward spiral. The spiral reached dangerous levels for some women before effective help was received. Winnicott (1965) used the term "holding environment" to describe the human need for containment of distress. Winnicott maintained that both adults and children need the sensitivity and availability of another person to "hold" or be "be with" their emotional needs (Powell, Cooper, Hoffman, & Marvin, 2009). In essence, many of the mothers who participated in the current study did not experience a holding environment. This concept supports the implications of attachment theory and affect regulation. If a mother's own attachment needs are not met, it will impact on her capacity as an attachment figure for her infant. Thus, a therapeutic treatment approach to PPD which is systemically orientated is indicated. The current study supports Knudson-Martin and Silverstein's proposal, "*PPD tends to be framed primarily as a medical problem. This metadata-analysis suggests that it is also a relational problem. Interventions that focus on developing supportive relationships that can sustain the emotional vicissitudes of childbearing have potential to empower rather than silence women."* (2009, p.157).

Further support for a relational or attachment-based approach to PPD, is the finding that for the majority of women in the current study, recovery was made through connection with others

and therapeutic support. Effective help in each case, was in the form of group therapy or one-to-one therapy. These findings are similar to those identified in the literature, (Beck, 2002; Knudson-Martin & Silverstein, 2009). All of the mothers stated that they believed that emotional support should have been offered earlier. They also placed value on empathy, kindness and having someone non-judgemental who would listen, normalise and provide hope.

Within the literature, it has also been found that women who have experienced PPD have a preference for talking therapies as opposed to pharmacology (Dennis & Chung-Lee, 2006). Women who experience PPD often feel isolated and full of shame and self-blame, (Beck, 2002). In support of Knudson-Martin and Silverstein's (2009) relational model of PPD, the current study identified that for all of the women interviewed, recovery was made through connection with others. Having their feelings normalised, and feeling accepted by a group or by a counsellor, assisted the women in accepting themselves, and forgiving themselves for not being perfect.

Yet, in spite of overwhelming evidence, the primary treatment for PPD continues to be medication, (Dennis & Chung-Lee, 2006). It is acknowledged that therapy is not a panacea and some women reported negative initial experiences of one-to-one counselling. Equally, the role of medication is important and in some cases life-saving. However, emotional and psychological support cannot continue to be offered as a last resort. Similar to previous literature (Knudson-Martin & Silverstein, 2009; Dennis & Chung-Lee, 2006), all eight women explicitly stated that early intervention with psychological support was needed.

Summary

As discussed, the "myth of happy motherhood" and of the "perfect mother" continues to influence women's expectations of motherhood. These expectations often lead to feelings of failure and inadequacy when women feel unable to live up to the idealised vision of

motherhood. This ideology is reinforced by the external environment. Yet, for many women, these external pressures do not cause postpartum depression and motherhood is experienced as a challenging but happy and satisfying time. As evident from the literature review, maternal history of trauma, insecure adult attachment, lack of social support and low self-esteem are risk factors for PPD. The current study highlighted that these pre-existing difficulties such as trauma, stress, low self-esteem and history of disrupted attachment, can cause painful feelings and memories to emerge following childbirth, perhaps making women who experience PPD more vulnerable to societal pressures and expectations. The shame and fear associated with PPD impacts on the mother-infant relationship by impinging on a mother's capacity to be emotionally available and to attune to her infant's needs. When a mother's emotional needs are not met and when her distress is uncontained by her environment, it is very difficult to keep giving and to meet her baby's needs. Current first-line treatments of PPD locate the problem within the mother, with little consideration of contextual factors. For all of the women in the current study, recovery was made through connection with others. These therapeutic relationships, whether in one-to-one or group format, served to provide a secure base from which to heal. Through this relational work, women learned to accept their flaws and adopt a more self-compassionate thinking style. Although many women found meaning from their experience through personal growth and helping others, the majority viewed postpartum depression as a horrific experience and expressed residual grief for the loss of memories and precious time with their babies.

5.4 Limitations of the Study

There are some limitations to consider in relation to the present study. IPA methodology utilises a double hermeneutic approach, thus the researcher's interpretations of the participant's

perception of their reality forms the basis of the analysis. As outlined in section 3.7 of the methodology, a number of steps were taken to ensure credibility of the results. The credibility of the findings could have been further strengthened if the researcher returned to the participants to seek their opinion on the interpretations, a process referred to as respondent validation (Barbour, 2001). However, this was not deemed appropriate or feasible due to the time limitations of the project and the additional time and distress which may have been caused to the participants.

As outlined in the methodology section, purposive criterion sampling was used in the current study. Participants were recruited from a charity who specialise in maternal mental health, based on the criteria outlined by the researcher. It is possible that the women who volunteered to participate in the current study were more likely to have experienced a positive outcome from attending therapeutic supports provided by the charity. However, the aim of the current research was not to provide generalizable findings, rather to provide a platform for exploring the experiences of a small number of women in an effort to better understand PPD and the mother-infant relationship. The women's experience of therapeutic input may have facilitated their self-discovery and understanding of their condition, thereby enabling them to provide rich, insightful data.

The qualitative, IPA methodology used in the current study is exploratory in nature and provides an in-depth representation of eight women's subjective experiences of PPD. The findings highlight some potential theoretical understandings of the experience of postpartum depression and of the mother-infant relationship during this time. However, further research which utilises a qualitative and quantitative approach to the topic, might serve to collectively represent women who experience PPD and provide more generalizable findings.

5.5 Strengths of the Study

The aim of the current study was to qualitatively explore the experience of postpartum depression and the mother-infant relationship, with women who have recovered from PPD.

The majority of qualitative studies of PPD have been completed with women who are currently experiencing an episode of postpartum depression. The current study provided rich accounts, from women who have recovered from postpartum depression and learned from their experience. As the majority of women had completed personal therapy and/or group therapy, they were able to provide valuable insights into their experiences and their self-discovery as part of the therapeutic process.

Another strength of the current study was the use of IPA in adding an interpretative layer to the mainly descriptive information available on PPD and the mother-infant relationship. Linking the qualitative findings from the current study to the quantitative findings in the literature review provides an insider's perspective on the interaction between maternal depression and the maternal-infant relationship.

Furthermore, the use of IPA methodology was appropriate in addressing the research questions. An appropriate sample size was obtained for the IPA methodology which is committed to gaining rich, detailed, idiographic accounts of an individual's perception and understanding of the phenomenon in question (Smith et al., 2009).

5.6 Implications for Clinical Practice

One of the alarming findings from the current study, was the way in which some of the women interviewed described their experience of the healthcare system. Many of the women felt dismissed, disempowered and silenced by the professionals they encountered. Considering the

serious implications of postpartum depression on maternal and infant mental health, it is imperative that more resources and attention are given to this area. The relationship between the mother and infant is the fundamental unit in which development takes place, (Seligman & Harrison, 2012). As pointed out by Kingston, Tough, and Whitfield (2012), investing in infant and maternal mental health initiatives makes sense from an economic viewpoint.

Postpartum depression is the most common complication of childbirth. Yet, the healthcare system focuses entirely on the physical needs of the mother and baby following childbirth. As identified, many women experience extreme shame and stigma for having PPD and consequently hide their depression from professionals due to fear. Thus, it is difficult to assess, diagnose and treat PPD. However, the assumption that women are coping and are not experiencing any form of mental health difficulty, reinforces the internal critical voice that they 'should be ok' thus maintaining the barrier to help seeking. This research supports the argument by Lefkovics et al. (2014) that there is a need for universal screening of maternal depression during the antenatal and the postpartum periods. By screening for mental health difficulties in the postpartum period, it acknowledges that depression and mental health difficulties are within the range of expected experiences following childbirth.

Furthermore, women in the current study and in previous studies, identified a preference for talking therapies and a non-judgemental approach. A number of women expressed the view that medication alone did not help them heal their negative beliefs and feelings which precipitated and maintained their depression. The current research highlights how pre-existing interpersonal difficulties tend to come to the fore after childbirth. These women's stories and the precipitating factors they identified, corroborate with the risk factors identified for postpartum depression. These factors include stress, history of trauma, negative core beliefs, attachment style and lack of support or systemic difficulties. Findings from the current study highlight how PPD is a complex condition with a wide variation in symptoms, severity,

chronicity, and contributing factors. The journey leading up to the point where a woman is sitting in her GP's clinic, is often long and complex, which in some cases, as we have seen, began in childhood with their own attachment figures (Ikeda et al., 2014; Robakis et al., 2016). The diagnosis of postpartum depression does not always encapsulate the complexities and idiosyncrasies of the experience. Unsurprisingly, many women feel dissatisfied and overlooked on receiving the diagnosis and subsequent prescription for antidepressants, or as captured by one participant; *"just pawning me off with pills"* (Claire).

These findings have implications for clinical psychology practice. Firstly, a role for formulation is implicated by the current research. Formulation is a collaborative endeavour, which seeks to examine an individual or family's difficulties and draw on psychological theories and principles to make sense of their distress (Johnstone & Dallos, 2006). Unlike psychiatric diagnosis, formulation seeks to understand the predisposing, precipitating, perpetuating and protective factors, which shape the presenting difficulties. Johnstone and Dallos, (2006) propose formulation as a means of reintroducing personal meaning, personal and social context and mutual collaboration into mental health work. Within the current study, much of the healing within these women's narratives involved a level of self-discovery and insight which can be achieved through formulation. In contrast to diagnosis alone, which left some women confused and feeling worse. As articulated by Ann; *I went to see my doctor and they diagnosed me with postnatal depression…it was very hard for me to take that on, take that on board because I didn't fully understand exactly postnatal depression...So I went home and I kinda down-spiralled with my postnatal depression, I, I felt very, I felt very suicidal."*

Formulation is central to the process of the therapeutic intervention (Johnstone & Dallos, 2006). As outlined, the role of therapeutic intervention in treating PPD is strongly implicated in the current research and supported by the literature. As discussed earlier, when a mother is experiencing high levels of distress, her ability to regulate her infant's distress in compromised.

McCuskey (2011) maintains that the role of the therapist is to regulate the client's distress to enable them to be a fear-free caregiver. Bowlby (1988), proposed that in psychotherapy, the therapist assumes the role of an attachment figure, providing a secure base from which the patient can safely explore and heal their internal working model of themselves and their attachment figures. As highlighted in the literature review, tentative support for these theoretical claims has been indicated in a very interesting preliminary study by Iyengar et al. (2014). The authors found that mothers who were 'reorganising' from an insecure to secure attachment style had infants with a secure attachment. The authors highlight the potential implications of these findings in a therapeutic setting. They suggest that therapeutic input, partner support or the birth of a child may contribute to the 'reorganisation' of attachment. These findings have important implications for the current study and the importance of formulation and therapeutic input. As was identified within the sample of women interviewed for the current research, much healing of self-concept and internal working models can be made from one-to-one psychotherapy, with the therapeutic alliance identified as the primary catalyst for change (Martin, Garske, & Katherine Davis, 2000).

As indicated in the literature review, interventions targeting maternal depressive symptoms have not been shown to improve the maternal-infant relationship (Gunlicks & Weissman, 2008). Interventions targeting both maternal depression and the mother-infant relationship have been proposed (Brummelte & Galea, 2016; Forman et al., 2007). The fact that the mother-infant relationship does not always improve after maternal depression symptoms have resolved, suggests one of two possibilities; firstly, that the impairment to the relationship during PPD is irrevocable or secondly that the impairments in the relationship were mainly related to the risk factors which contributed to the PPD rather than the PPD itself. As outlined in the literature review, the pathway from maternal depression to insecure infant attachment is not clear-cut. Thus in clinical formulation, consideration of the maternal history is important and has

implications for treatment. As treatment of depression alone is not always sufficient to address the mother-infant attachment relationship, in some cases, additional input is needed. The current study identified how women can experience difficulties attuning and regulating their infant's distress due to feelings of inadequacy or fear. The impact of these difficulties on the maternal-infant attachment can maintain the depression as the mother feels inadequate. Therefore, unless these core difficulties are resolved, ongoing impairments in the mother-infant relationship may be apparent, despite the resolution of depressive symptoms.

Clearly, postpartum depression is a complex condition with a wide variety in predisposing, precipitating and perpetuating factors. These factors must first be assessed and formulated before treatment is devised. For some women, as highlighted, this will require psychotherapy involving attachment or trauma based work, or addressing negative core beliefs and possibly maternal-infant psychotherapy. For other women, connecting with others in group format may be sufficient to normalise their experience, encourage self-compassion and build supports. One approach does not fit all, therefore a collaborative working relationship between primary care, adult mental health and infant mental health is implicated. Ideally, a maternal mental health team would manage all referrals, complete the assessment and adopt a stepped-care model which determines the most appropriate intervention based on psychological formulation.

In light of the overburdened, under resourced health service, particularly within mental health, a number of strategies may be used to facilitate this maternal mental health programme. Firstly, it is recommended that charities such as Nurture, from which the current sample were recruited, may supplement the health service. All of the women in the current study accessed their 1-1 therapy privately, rather than through the public system. Nurture attempt to address the gaps in public service provision by providing 1-1 counselling and group work. However, they do not receive any funding from the health service and rely on fundraising and grants.

Within the current study, group therapy was identified as beneficial by a number of participants. As identified by J. Goodman and Santangelo, (2011), group treatment for PPD represents a cost-effective and resource-effective solution which addresses the social support needs of mothers, provides the opportunity for women to feel less isolated, to have their feelings and experiences normalized and thus feel less alone, all of which have been identified by the participants in the current study as important. In addition, the non-judgemental approach and shared experience of being a mother with PPD, appears to facilitate the development of self-compassion and self-acceptance.

As identified, the cultural and societal expectations and attitudes towards motherhood are not helpful to women with PPD. Charities such as Nurture, complete invaluable work behind the scenes in raising awareness and breaking down barriers for women accessing services. Maternity hospitals, antenatal classes, midwifes and public health nurses are also ideally placed to break down barriers to help-seeking by banishing the myths and providing information about postpartum depression and the wide range of emotional experiences women can expect following childbirth.

5.7 Implications for Further Research

As outlined, many of the women identified group and 1-1 therapeutic work as an essential element of their recovery from postpartum depression. The women interviewed identified that through this therapeutic work, they learned to adjust their expectations on themselves and adopt a more self-compassionate internal voice. The quantitative research also supports the effectiveness of therapeutic support in treating PPD (J. Goodman & Santangelo, 2011; Stuart, 2012). Future qualitative research exploring therapist's experiences of working with women who have PPD might provide very valuable insights into the condition.

5.8 Concluding Comments and Reflections

Completion of the current study was both rewarding and challenging in equal measure. Difficulties in recruiting a sample of participants was the first obstacle which caused a delay to the project starting. In addition, the scale of literature covering the topic of postpartum depression and maternal-infant attachment was overwhelming at times.

In terms of gathering data, one of the challenges encountered was that during interviews, many participants tended to focus on their general experience of postpartum depression, rather than specifically on their relationship with their baby at that time. It became apparent that this was the most difficult and painful part of their experience to reflect upon. This was a worry, as the main focus of my study was initially on women's perceptions of their relationship with their baby during PPD. I worried that my research would not add anything 'new' to the literature base and I became overly concerned with the originality of the study. On reflection, I found that completing the interviews with these eight women, who gave their time so generously and hearing their emotive stories contributed to the pressure I felt to 'make a difference' with this research project. Discussion of the project with my supervisor helped clarify the ways in which the project would add to the literature base, as outlined in the strengths of the research section.

This project represented my first time using interpretative phenomenological analysis. As a methodology I found it refreshing and particularly fitting to the topic I was studying. Smith, Flowers and Larkin's (2009) IPA text book was very accessible and provided useful guidance in carrying out the analysis. However, the analysis was labour intensive and felt never ending at times. Overall, I believe that I have learned a lot from the methodology and I believe that the learning outcomes from the detailed analysis of the transcripts will help me in my clinical practice.

In terms of rewarding aspects of the project, on a personal level I found the narratives of the women riveting and their strength, humanity and resilience inspired me. The use of a reflective journal was important following the interviews and served as a mechanism of debriefing from the emotional impact of hearing, and at times containing the distress felt by the women. I felt that my clinical training assisted me in dealing sensitively with the interviews and in managing my own emotional reactions. The process of completing this project has further developed my interest in infant and maternal mental health and it is an area I would be interested in focusing on, in my future career as a clinical psychologist.

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APPENDICES

Appendix A: Participant Information Sheet

UNIVERSITY of LIMERICK

OLLSCOIL LUIMNIGH

Information Sheet

"Irish Women's experience of caring for their baby through postnatal depression"

Hello,

My name is Éadaoin Clogher, I am trainee clinical psychologist with the University of Limerick. I am completing research, as part of my doctoral thesis, on Irish women's experience of postnatal depression and caring for their baby. I would like to invite you to take part in this research.

What is the research about?

This research aims to gain the valuable views, opinions and experiences of women who have recovered from postnatal depression and how they cared for their baby during this difficult time. This information will further our understanding of postnatal depression and the mother-baby relationship. It is hoped that this research will increase awareness of postnatal depression and help to improve supports and interventions for women and their babies.

Who can take part?

I will be interviewing a maximum of 12 mothers who have previously experienced postnatal depression. I have asked the counsellors in Nurture and Mammy Matters to provide this information sheet and invitation to women who might be interested in participating.

What is involved?

The interview will last approximately one hour and will take place at a time and venue that is convenient for you. During the interview, I will sit down with you and ask you about your experience of postnatal depression and caring for your child during this time. If you do not wish to answer any of the questions during the interview, you may say so and I will move on to the next question. The interview will be audio-recorded and treated with strict confidence. No-one else except the principal investigator, Dr Patrick Ryan, will have access to the recorded interview. I will type up the interview and you will have an opportunity to read it if you wish. Once you have had this opportunity, the audio recording of your interview will be permanently deleted. The transcript of your interview will be anonymised and will be stored on the researcher's laptop with a protection password. The anonymised information will be kept for a period of 7 years, after which it will be destroyed.

What are the benefits to you?

There will be no direct benefit to you, but your opinion, views and experiences are highly valued and your participation is likely to help us find out more about postnatal depression and how best to support mothers and children. As a small token of our appreciation for your valuable time and contribution, you will be provided with a €10 gift voucher.

What are the risks?

You may finding it upsetting to talk about this difficult time in your life and this period of your child's life. You can be assured that the interview will be conducted in a non-judgemental, sensitive manner. Should you find the experience very upsetting or overwhelming, a counsellor will be available to you to provide support.

What if I do not want to take part or change my mind during the study?

Your participation in this research is entirely voluntary and you can choose not to consent or to withdraw consent and stop participating in this study at any time. If you choose not to participate, any services you receive will continue and nothing will change.

What happens at the end of the study?

At the end of the study the information from all of the interviews will be used to present findings about postnatal depression and mother-infant relationships. The information will be completely anonymised and nothing will be attributed to you by name. The knowledge that we

gain from this research will be shared with you before it is made widely available to the public. Each participant will receive a summary of the results. The researchers will seek to publish the overall results so that other interested people may learn from the research.

If you have any questions or would like any further details about the study, please contact the Lead Investigator, Éadaoin Clogher at 12022357@studentmail.ul.ie or telephone 087 9337476 or the Principal Investigator Dr Patrick Ryan at Patrick.ryan@ul.ie or telephone 00353 61 202539.

Thank you for taking the time to read this. I would be grateful if you would consider participating in this study.

Yours sincerely,

Éadaoin Clogher,	Dr Patrick Ryan,
Psychologist in Clinical Training	Head of Psychology Department

This research study has received Ethics approval from the Education and Health Sciences Research Ethics Committee (2015_10_26). If you have any concerns about this study and wish to contact someone independent you may contact:

Chairman Education and Health Sciences Research Ethics Committee

EHS Faculty Office

University of Limerick

Tel (061) 234101 16

ehsresearchethics@ul.ie

Appendix B: Participant Informed Consent Form

UNIVERSITY of LIMERICK

OLLSCOIL LUIMNIGH

Informed Consent Form

"Irish Women's experience of caring for their baby through postnatal depression"

- I have read and understood the subject information sheet.
- I understand what the research is about, and what the results will be used for.
- I consent for the data to be used anonymously in report format and published output.
- I am fully aware of all of the procedures involving myself, and of any risks and benefits associated with the study.
- I know that my participation is voluntary and that I can withdraw from the project at any stage without giving any reason.
- I am aware that my recorded interview and information will be kept confidential.

Volunteer's name _____

Volunteer's signature _____

Date _____

Investigator's signature _____

Date _____

Appendix C: Debriefing Sheet

UNIVERSITY of LIMERICK

OLLSCOIL LUIMNIGH

Debriefing Sheet

Thank you for taking the time to participate in this research.

Your contribution is valuable and will help us to better understand postnatal depression and the mother-baby relationship. It is hoped that this research will contribute to public awareness of postnatal depression and help to improve supports and interventions for women and their babies.

If you would like further information on this study please do not hesitate to contact either myself or my supervisor using the contact details provided below:

Researcher:

Éadaoin Clogher,

Psychologist in Clinical Training,

Department of Psychology,

University of Limerick,

Co. Limerick.

Email: 12022357@studentmail.ul.ie

Supervisor:

Dr. Patrick Ryan,

Head of Department

Department of Psychology,

University of Limerick,

Co. Limerick.

Email: patrick.ryan@ul.ie

Phone: 061 202539

If you feel you may have been affected by this interview and feel distressed, please speak to a counsellor at **Nurture** (01) 843 0930 or your GP or one of the counselling/support services listed below:

Samaritans

Free phone: 116123

Website: www.samaritans.ie

Email: jo@samaritans.org

Aware

Phone: 1890 303 302

Website: www.aware.ie

Email: supportmail@aware.ie

Appendix D: Interview Schedule

1. Tell me about your personal experience of postnatal depression.
    - When? (How long ago/which child/how soon after birth)
    - What symptoms/thoughts/feelings did you have?
    - What treatment did you receive? (Medication/therapy/hospitalised)
    - Duration of episode

2. How did this effect your experience of caring for your baby?
    - What was your relationship like with [baby's name] at the time?
    - How did you feel about [baby's name]?
    - How did you feel about yourself as a mother?

3. What helped you get through that difficult time?
    - How did you get through it?
    - What helped?
    - What else (if anything) would have helped?
    - What support did you have?

4. Background Questions:
    - Age?
    - Relationship status?
    - Number of children?
    - History of mental health problems?

Appendix E: Ethics Approval Letter

Dear Patrick

Thank you for your amended Research Ethics application which was recently reviewed by the Education and Health Sciences Research Ethics Committee.

The recommendation of the Committee is outlined below:

Project Title: 2015_10_26_EHS Women's experience of postpartum depression and mother-infant attachment: An interpretative Phenomenological Analysis.

Principal Investigator: Patrick Ryan

Other Investigators: Eadaoin Clogher

Recommendation: Approved until October 2016.

Please note that as Principal Investigator of this project you are required to submit a Research Completion Report Form (attached) on completion of this research study.

Yours Sincerely

Anne O'Brien

Anne O'Brien
Administrator, Education & Health Sciences
Research Ethics Committee
Ollscoil Luimnigh / University of Limerick
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Appendix F: Sample Interview Transcript with Exploratory Comments

Emerging themes	Original Transcript	Exploratory comments
	going to be getting you off the meds it's going to be getting you on the meds, which was true. And the psychiatrist, when, we had a grudging respect after a period of time, where he would talk to me, but occasionally, he, like at one point he said to me, (raised cross voice) me doctor you patient (laughs). *I: Oh my god* P2: I had pissed him off so much because he had said he wanted to reduce one of the meds and I was coming home for a weekend. And I thought, over thinking everything, right they're going to stop me on a Thursday, withdrawal tends to kick in two days later, (gasp) how will I know, how will if it's the anxiety or how will I know if its withdrawal. *I: Yea* P2: So of course I go back, I ask can I see him, and I said to him look maybe we should keep me on the Sertraline til, and this is when I got this response, and something clicked in me in that point and I thought now your being ridiculous, but I also thought, actually fuck you, don't you <u>dare</u> speak to me like that, and something clicked at that point and I kind of went out of there for the first time angry. *I: Mmhm* P2: And.. it definitely helped, it definitely helped, because again I got caught into this, this might	Developed a grudging respect between her and psychiatrist – he found her difficult to deal with, she challenged his decisions and questioned everything, needed to understand her treatment plan *(raised cross voice) me doctor you patient* <u>Disempowering again, authoritative 'expert' approach</u> <u>Power struggle</u> She can see now that she was over-thinking it- needed the change in meds to be explained and it felt like he did not explain what he was doing <u>Psychiatrist trying to stifle her voice, induce helplessness.</u> *but I also thought, actually fuck you, don't you <u>dare</u> speak to me like that, and something clicked at that point and I kind of went out of there for the first time angry.* <u>Only time she swore in interview – demonstrates how angry she felt.</u> <u>Was she also embarrassed, did he humiliate her, belittle her?</u> <u>Something clicked - Something kicked in- survival – fought against it.</u> <u>Anger is energising</u> Definitely helped – repeated, <u>made her determined?</u>

	help me and you're not listening. What I failed to see.. was.. that he knew that by starting to reduce the dosage, we were also able to see what was happening, but they didn't explain any of that to me and I need it explained. *I: Yea yea* P2: I think his view would be, I don't need to explain things to you. *I: Trust my opinion* P2: And a lot of the time he was right, but some of the time he was wrong. Em and I have to say, when I came back that first night and I was in floods of tears, I kept saying to him, I've let everybody down, I've let home down, I've let you down and he gave me the most unmerciful kick under the table and went you haven't let anybody down but you certainly haven't let me down. So, seeing that human face was very important, (tearful) very very important and then just over time and spending more and more time, with that graded exposure, it began to make it a bit easier. A little bit. *I: And when, would you be comfortable talking a bit about your reaction to the twins when you saw them* P2: Sure, and apologies for crying, unfortunately its still quite raw *I: No not at all, it's only, it's only been.. just over a year has it* P2: It's a year, 13th of June a year ago, I went back to work, ironically, on world suicide prevention day on the 10th of Sept, and that helped, going	*you're not listening*. Not being listened to again Did he say this later or is this her deduction of his intent? Experienced psychiatrist as patriarchal, dominant, arrogant, not willing to explain himself Believes he was mostly right, sometimes wrong Seeing the humanity and kindness in the psychiatrist – *very important, (tearful) very very important* – essential part of recovery and healing Seeing this compassionate side to him made up for how he had previously treated her and was experienced as very poignant and important *graded exposure.. make it a bit easier. A little bit* Graded exposure to the babies – interesting choice of words, like she had a phobia of them, her fear and anxiety was so strong reassuring me that she is ok despite the tears Going back to work – *developing that side* – restored her self-confidence/identity/self-belief

	back to work developing that side also helped as well My reaction to seeing the twins, when I saw them the first time when (husband) brought them in, I was terrified and that came out also as anger and (husband) couldn't do anything right, he just as far as I was concerned, you know, he would leave, he left (son) sitting on my lap and I was just take him away take him away take him away because I was just terrified. *I: Ok Yea* P2: (Daughter) always worried me more because she was so teeny tiny. *I: Yea* P2: And there was a lot in that relationship. (pause) And yet she was the one who was actually very happy to just sort of sit and look. *I: Yea* P2: But the first time was hard, the second time wasn't a whole heap better, (smiled crying) to be perfectly honest. Again, I became fixated on routine, I'm still a bit like that to be perfectly honest, and that wouldn't be unusual, I was quite like that beforehand that wasn't a big personality change. *I: Yea* P2: Em I became fixated on.. if you're not doing this right then of course they're going to cry they're going to be upset they're going to be that, so when I saw them, it became very much an interrogation of (husband) of what did you do when and what happened [….] Em but I would hold him to task. So a lot of the time when I was	Returns herself to the question I asked when she could have stayed with the topic of work Primary emotion on seeing the twins for first time since admission was fear, came out as anger <u>Couldn't tolerate holding her son – anger with her husband was probably an easier emotion to deal with than her feelings about her son</u> Concern about her daughter's physical health *there was a lot in that relationship* – thinking out loud here? I did not probe further, what she is referred to is probably beyond the scope of the interview- <u>perhaps something she is working on in therapy – mother daughter relationship – echoes of her own relationship with her mother</u> <u>doesn't say how she felt about the babies but no evidence of love or bond felt at this stage – sheer terror blocking any positive feelings or emotions</u> fixated on routine and criticising her husband – something concrete to focus on, avoids feelings towards babies and herself *that kept me safe in some ways because it put a bit of distance between myself and themselves (tearful)*

	with them, it was about interrogating and again that kept me safe in some ways because it put a bit of distance between myself and themselves (tearful), *I: So you could focus on the practicalities* P2: Or obsess about the practicalities. I think the turning point for me was.. I went over to […] and I bought clothes for them (long pause, tearful) and that was my way back.. having knowing that I had an interest in doing that… that's..(the start) *I: That was when you felt things were changing* P2: And it was very up and down and I think when downs come, when I would see them and I would be upset, (voice v tearful) it would be harder because I had this expectation that it would just go, and it didn't (v tearful), it really didn't. (Breath in) But at that point I was able to care for them, I was scared of them but I was able to care for them. Em and there was also something about.. I began to feel like I was coming back a bit, because I did go, and I couldn't face it at the time.. I did go through that my life was over… *I: Yea* P2: I can't do it. This is it. This is it I don't want this. *I: Yea* P2: But at the time I couldn't, couldn't admit to it. *I: Yea* P2: Because.. the shame of that was enormous, I mean, here was, here were these really really	very insightful. She shielded and protected herself from the overwhelming feelings towards her babies by focusing her frustration and anger with her husband. What were the primary feelings? What was the impact on the attachment? Husband primary attachment figure? Control is huge for her – how she manages her anxiety *I bought clothes for them (long pause, tearful) and that was my way back* Very very poignant moment in the interview – what she sees as turning point in relationship with her twins. – having an interest and desire to buy clothes for them, suggests for the first time that she could see a future with them and with her in it. That was my way back- back into their lives *It would just go-* what would just go- Fear of the babies? Resentment? Feeling like she did not wanting them or feeling like she didn't love them? - something she could not put into words Moves away a little from this painful memory Scared of them but able to care for them – able to go through the motions but no emotional connection Her sense of self returning a little – *I was coming back* (into myself) Began to accept the change - that she could live this new life Previous thought her life was over – no escape other than running away/suicide/death of the babies *I can't do it. This is it. This is it I don't want this.* Not able to fully articulating what 'it' is. It = the babies. Did not want the babies *And I didn't want them anymore.. Because, and it wasn't that I actually didn't want them, I did not want the anxiety*

	wanted babies. And I didn't want them anymore. Because, and it wasn't that I actually didn't want them, I did not want the anxiety. *I: Yea* P2: And if that meant that I had to bundle them up into that too then that's what I would do. And it was awful, it was awful. *I: Mmm (pause)* *So it sound like as you started to feel better but those, the feelings that you expected to come back about the children didn't* P2: Not as quickly as I wanted them to. *I: Yea* P2: Not at all. And I think there was something about, I had always been a high achiever, more through hard work than anything else, not sort of an entitlement but I can do that I can do that I can do that.. I couldnt do it, and it was probably the first time in my life I came across something that I wanted to do but I couldn't. *I: Yea* P2: And that belief system, everything just came crashing down. *I: Yea yea* P2: And that if anything I'd say led to the depression as well as the complete lack of sleep. Em, that was a huge amount to do with it and a feeling that <u>nothing</u> would ever change *I: You felt stuck* P2: Totally. And each day would start, and the anxiety was the strongest in the mornings, and all I kept saying was this can't be it, I mean I have to	<u>Says it here but almost takes it back or reframes it. Still too much shame attached to that sentence</u> – *I didn't want them* *it was awful* – the anxiety and depression and feeling like she did not want her babies <u>Loss of self-belief, identity, confidence</u> <u>Breakdown of her whole Internal working model of herself</u> *And that if anything I'd say led to the depression as well as the complete lack of sleep* Anxiety was there - then as a result feeling unable to be a mother to the babies - shame of that and feeling utterly incompetent led to the depression Feeling stuck, trapped, no way out, could not see any light at the end of the tunnel Conveys feeling of panic – felt like an impossible situation and could not see an end or way out

Appendix G: Sample excerpts from Reflective Journal

03/12/15

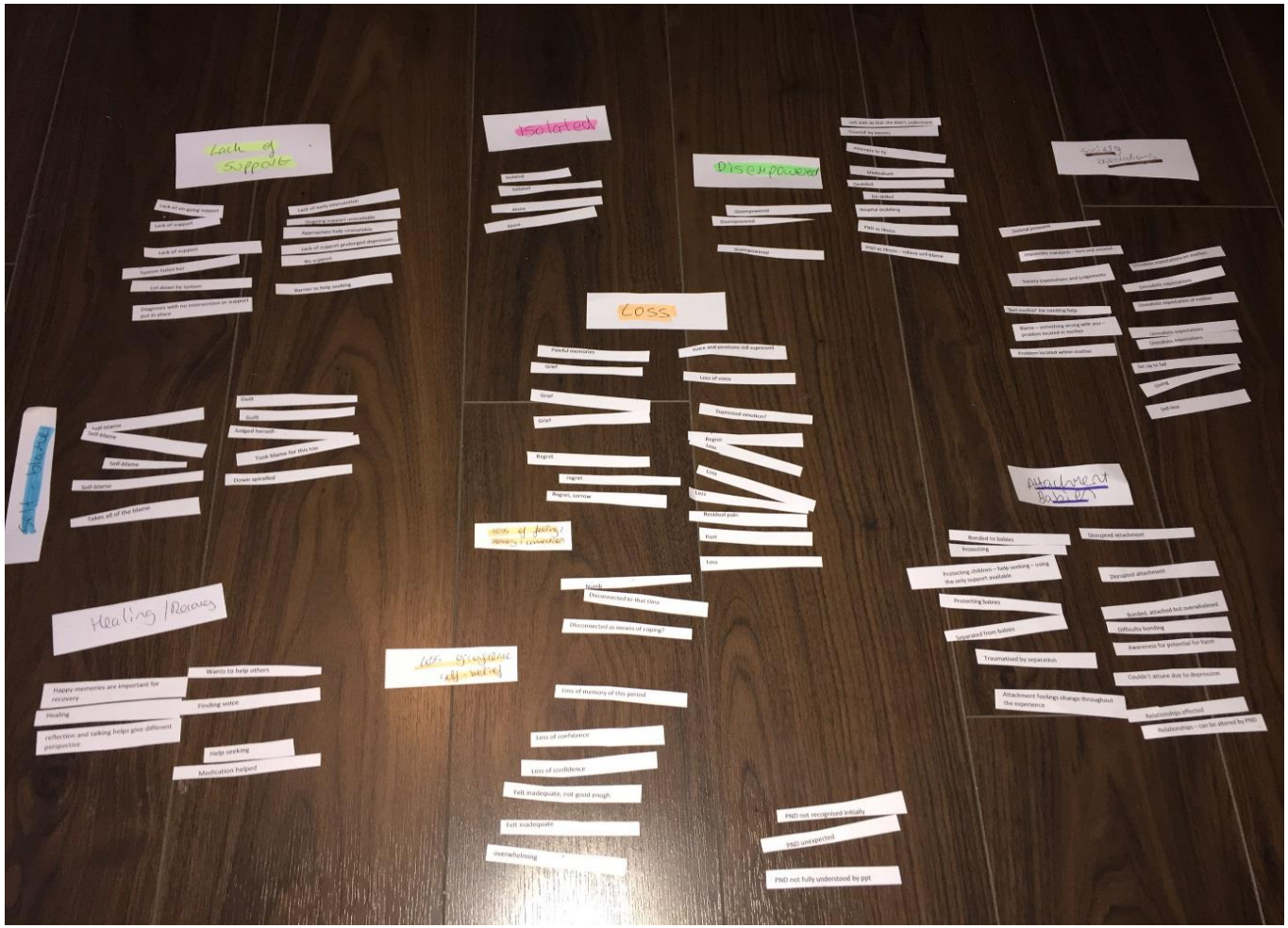
Difficult interview. Participant, N was very warm, friendly and articulate. She was very emotional throughout the interview. Still very raw for her. The interview ended up being quite unstructured as I allowed her to lead and did not probe very much. As it was still clearly very very painful, I was conscious not to cause further distress. Felt a lump in my throat at one point and had to work hard to remain composed. Difficult to retain the roll of researcher rather than therapist. Met her husband and twins before the interview and they were downstairs throughout the interview, which probably made it more real. Also, as a woman and a mother and coming from a similar profession, her distress resonated with me. Left extra time for debriefing and grounding at the end of interview. Felt slightly emotional when replaying the interview when I got home. N emailed me later with links to articles on PPD. In her email she thanked me for my sensitivity during the interview.

13/12/15

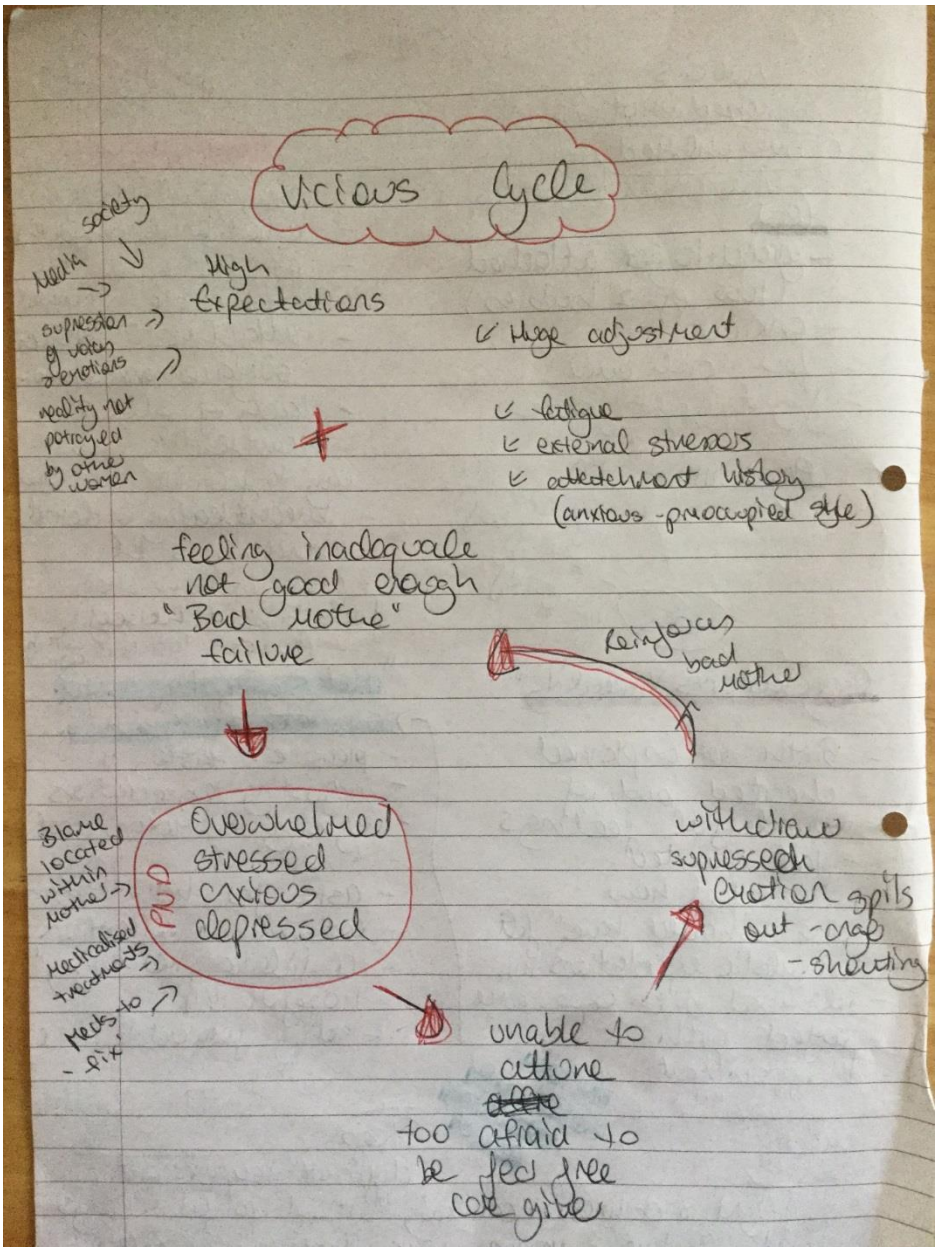
Transcribing P's powerful interview. Feel that I am learning so much from her; her insight into mental health - her own and the nature of conscious and unconscious mental states in general. Notion of vicarious resilience comes into my head and I am struck by how much I am gaining from these interviews. Possibly some lasting negative consequences for the children of the women who suffer from PPD, as P said, 'you do pay a huge price' but these women have come through it and also have so much to offer, so much strength, resilience, care, self-awareness and humanity that surely this must equally contribute to their children's development, as P said 'your children see everything you can be then, once you get back on track'. Do need to be aware of these assumptions however when I am interpreting the data.

Appendix G: Samples of Various Stages of Analysis

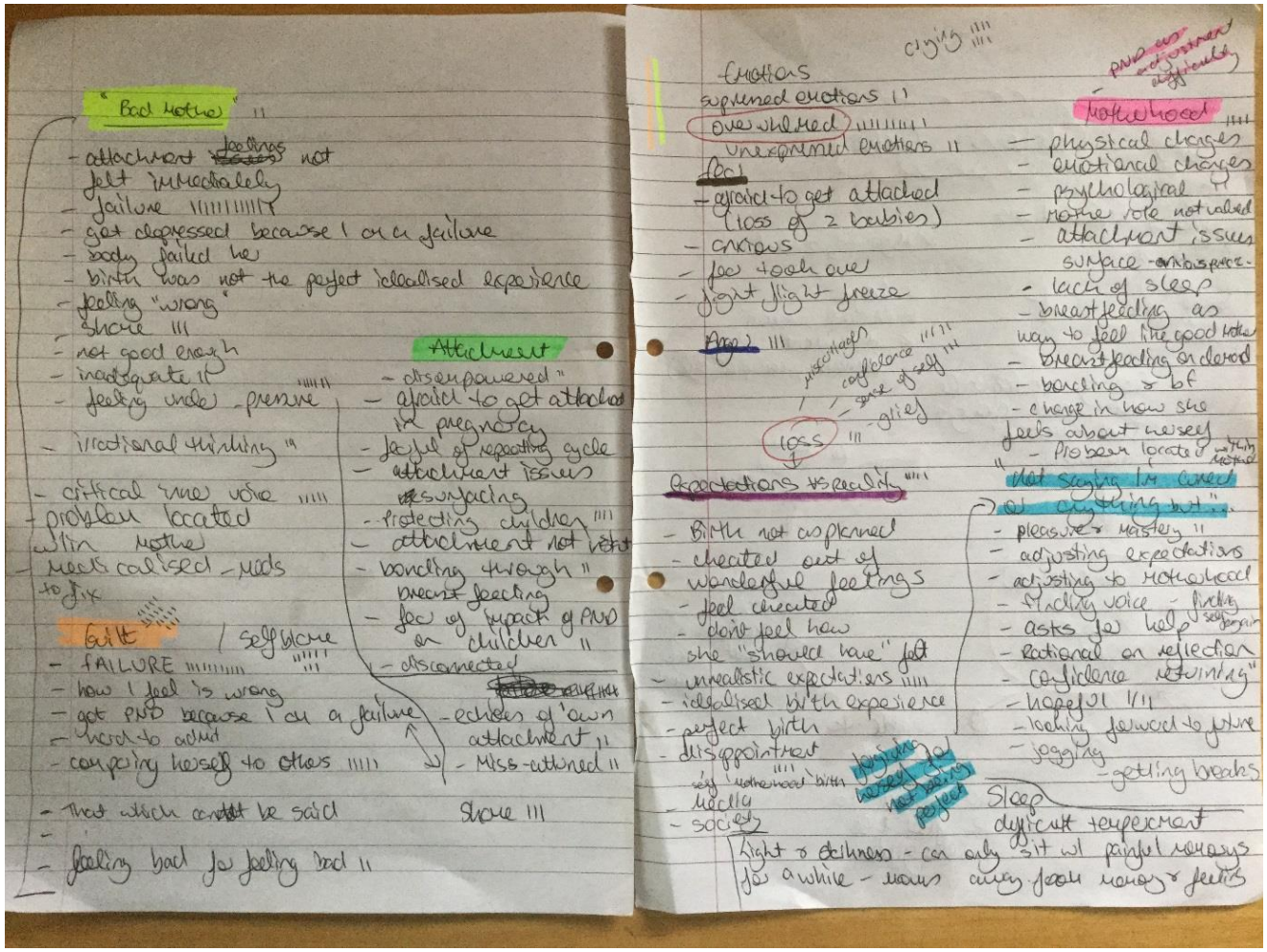
Physical Arrangement of Themes from one interview



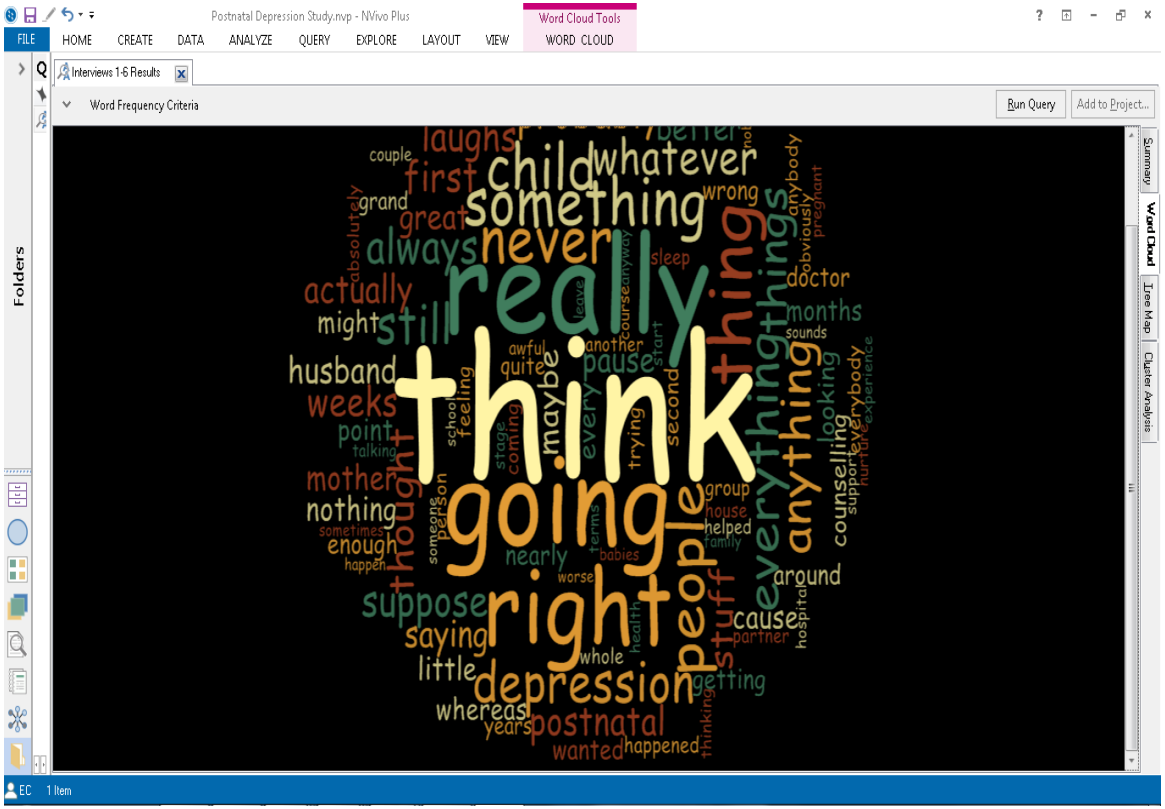
Example of a map of emerging themes from one interview



Example of subordinate themes from one interview



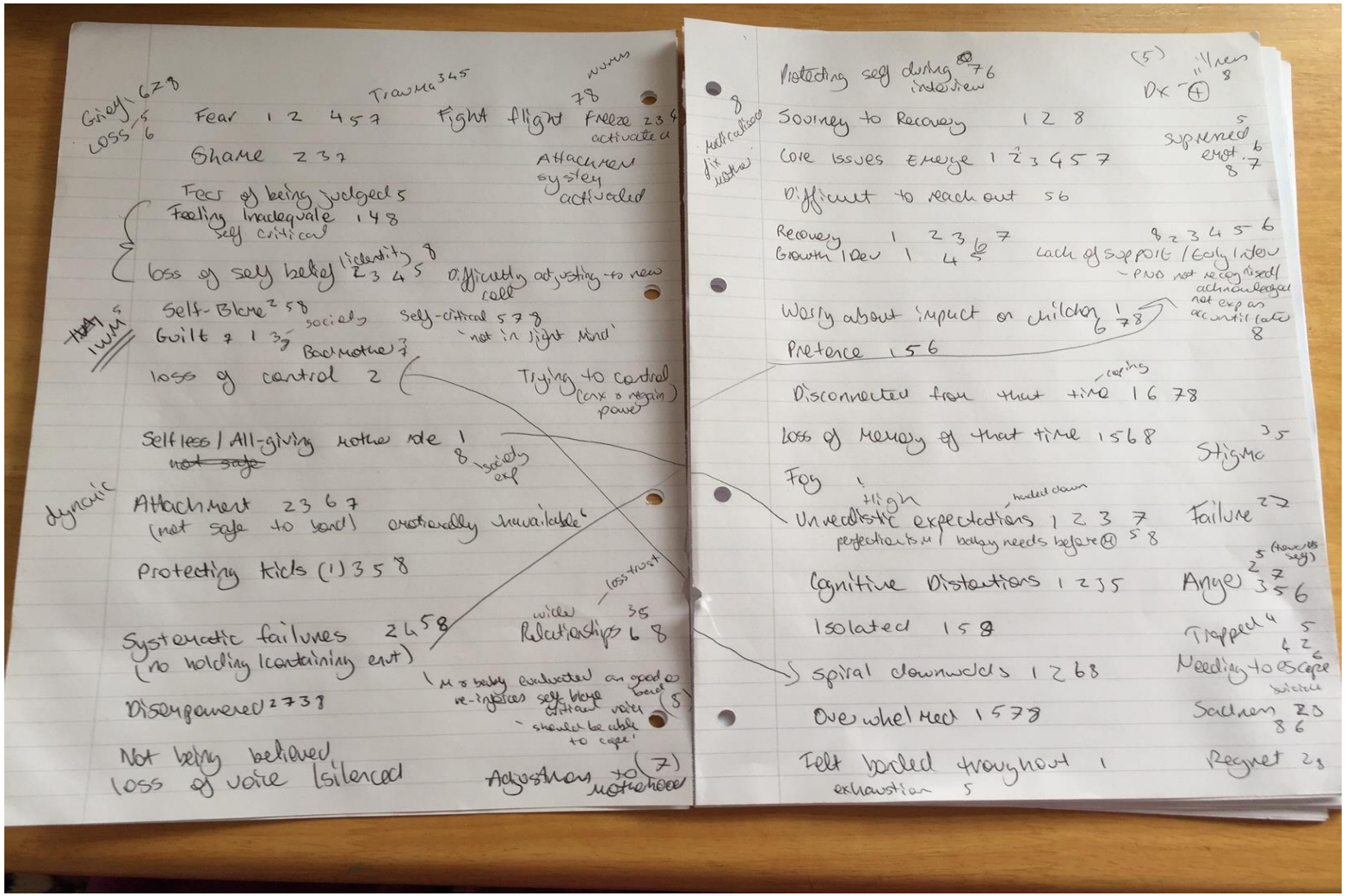
NVivo Word Cloud



Reflective memo:

I found it interesting and fitting that the most prominent word in this word cloud is 'think'. In a way, this reflects the 'phenomenological attitude', (Husserl, 1927), evoked by IPA research and also captures the double herumeneutic underpinning of the IPA approach, as Smith et al,. (2009) stated; the end result is always an account of how the analysist thinks the participant is thinking' (p.80).

List of Subordinate themes with participant numbers



Mind Map of subordinate and super-ordinate themes